Illinois' Strong Foundations Partnership – Grant X02MC19400

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Assessment of Current Need and Capacity

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Executive Summary

Overview

The Maternal, Infant, and Early Childhood Home Visitation Program included within the Patient Protection and Affordable Care Act will support States in implementing evidence-based home visitation services for pregnant women and newborns and their families. The specific outcomes targeted by these programs include improved maternal and newborn health; prevention of child injuries, child maltreatment and reduction in emergency room visits; improved school readiness and achievement; reduction in crime or domestic violence; improvement in family self-sufficiency; and improvements in the coordination and referrals of other community resources and support.

The Illinois Department of Human Services and Home Visit Task Force contracted with Chapin Hall to conduct a statewide the needs assessment as specified in the legislation. Chapin Hall's effort included two core components:

- Identifying communities with high concentration of specific social dilemmas and negative outcomes for children including premature birth, low-birth weight infants, infant mortality, particularly early death due to child maltreatment; poverty; crime; domestic violence; high rates of school drop-outs; substance abuse; unemployment; and child maltreatment.
- Assessing the quality and capacity of existing early home visitation programs, other early childhood resources and substance abuse treatment programs in the State for the purposes of determining the number of families and children being served by these efforts; existing gaps in the early childhood service system; and the extent to which these programs are effectively meeting the needs of those being served.

In completing this task, Chapin Hall staff utilized State administrative data and surveyed direct service administrators and program managers engaged in delivering four evidence-based home visitation programs – Nurse Family Partnership, Parents as Teachers, Healthy Families Illinois, and Early Head Start. In addition to analyzing these data, the Chapin Hall team also conducted a careful review of the most recent Title V needs assessment, the community-wide strategic planning and needs assessment developed under the Head Start Act, and the inventory of unmet needs and current community-based and prevention focused activities under the Community Based Child Abuse Prevention Program (CAPTA). The final recommendations reflect the finding of our own work as well as those documented in these earlier assessments.

Key Findings

The needs assessment process and findings offer the State a strong foundation on which to build a more coordinated and comprehensive approach to providing appropriate support to pregnant women and new

parents. Further, the process confirmed and, in many instances, enhanced the recommendations and findings that have emerged in other statewide needs assessments, including those conducted as part of the Title V MCH Block Grant Program, the CAPTA inventory of unmet needs, and the Head Start strategic planning process.

High Risk Communities

Using administrative data, we identified the highest risk areas in each of three community clusters – neighborhoods within the City of Chicago; townships in the balance of Cook County and Lake, DuPage, McHenry, Will and Kane Counties; and counties across the balance of the state. Regardless of how we measured risk, communities presenting the greatest challenges for young children and their families include:

- Neighborhoods on Chicago's Westside (particularly East and West Garfield Park and Greater Grand Crossing); the Southside (particularly Fuller Park, Washington Park, West Englewood and Englewood); and the far Southside (particularly Riverdale);
- Townships in both the western and southern portions of Cook County (particularly Cicero, Bloom and Calumet townships); the northeastern portion of Lake County (particularly Benton and Zion township); the northwest portion of McHenry County (particular Chemung township); and the Joliet area in Will County; and
- Several counties throughout the State including a cluster of counties at the far south tip of the State (Alexander, Massac and Pulaski), the south-central counties of Jefferson and Marion, the central counties of Macon, Vermilion and Knox, and northern Winnebago County.

These data underscore that many young children throughout the state are living in families that are characterized by poverty and involvement in multiple services systems including mental health, substance abuse and child welfare. Because of the variation in context and resources across these three community clusters, however, it is difficult to directly compare the need for services across all three groups.

General Service Capacity and Implementation

Overall, one or more state agencies have made investments in two Nurse Family Partnership sites, 42 Healthy Families Illinois sites, and 232 Parent as Teachers sites. In addition, there are currently 25 Early Head Start sites operating throughout the state. Collectively, it is estimated that these programs served approximately 20,000 families in FY 2009. Survey data from a sample of these programs, however, suggest that the state's budget crisis and general economic conditions are having major impacts on service capacity. Eighty-five percent of the managers responding to our survey indicated that recent state budget cuts and funding uncertainty has had moderate to substantial impacts on their operations, contributing to staff layoffs, reduction in staff hours, increased caseloads or reductions in supportive services, or cuts in

professional development opportunities and training. Not only does each of these issues impact capacity, they can, over time, have implications on program quality.

Program Availability Relative to Need

The location of EBHV programs is highly concentrated in the Chicago metropolitan area and that portion of the State across the river from St. Louis, MO. Roughly one-third of the counties have no home visitation program and another third have only one program. In most cases, the single program available in communities outside of Chicago and the greater St. Louis area is PAT, although the relatively small number of EHS and HFI in the state are found in both urban and rural areas.

Based on the information we have available on all of the EVHB programs, it is difficult to discern the exact scope of each program's catchment area. In most cases, the only consistent "location" information we had for all of the programs was the address of the entity or organization which received the grant or managed the program. This location may or may not fully represent a program's actual service area. For example, the management staff or fiscal agent for PAT programs is often housed within the administrative offices of local districts. Actual services, however, may be extended to families throughout the school district. Similarly,a large non-profit may be the administrator or fiscal agency for an EHS or HFI site but services may be delivered in a location in one or more communities located outside the business office's immediate area. Consequently, our preliminary assessment may over or under estimate current capacity in any specific community or area of the state.

In the absence of being able to better specify the reach and capacity of each service program, it is difficult to assess the degree to which current levels of investment are adequate or if they are being allocated in the most efficient manner. While it does appear some communities may have a richer array of services than other areas at equal or higher risk, the distribution of services is only partially a function of a community's level of risk as defined by the types of health and well-being measures available for our analysis. It is possible other dimensions of need such as the proportion of undocumented families living in a community or the loss of other critical family support services may justify the expansion of EBHV options in a given area. Further, communities will differ in their capacity to implement and sustain an EBHV program including the capacity to secure initial and ongoing funding, to hire and retain a qualified work force and to have access to the full range of supportive and therapeutic services program participants may need. Communities that have robust leadership within its school districts, local public agencies and non-profit organizations may find it easier to expand services than communities without this level of leadership. In determining how best to allocate new resources or realign existing resources, it will be important for the State to build on this initial assessment and obtain more comprehensive

information on the characteristics of local populations and the capacity of local service systems before committing to expanding programs in any given community.

Program Quality Issues

In addition to having a sufficient number of service opportunities for high risk families, it is equally important that those services that are available reflect high quality. Although the identification of service quality is a complex and ongoing process, our survey of program managers allowed us to examine some preliminary quality indicators. Among the most important features observed within the existing pool of EBHV programs are the following:

- **Credential/certification status**: Seventy-four percent of the programs represented in the survey have been reviewed by the relevant national model and found to be in compliance with model guidelines. Looking across the four models we examined, 56% of the HFI sites hold a Healthy Families America Credential; 48% of the providers delivering PAT have completed their self-assessment (the first stage in obtaining PAT Commendation); both of the local NFP sites have had their program's operational plan approved by the NFP National Service Office; and 88% of the responding EHS sites have completed a Federal Review with no deficiencies. While we cannot be certain that those programs not responding to the survey have achieved similar compliance with national model specifications, it would appear the majority of State providers are operating in a manner consistent with national model expectations.
- **Enrollment and retention levels:** On balance, the vast majority of families referred to these programs accept enrollment. Less than 5% of the program directors we surveyed indicated that more than a quarter of their referrals refuse enrollment. Indeed over 70% of respondents reported that less than 10% of those referred for these intensive home visitation services refuse this assistance. Of those program managers responding to the survey, the average home visit completion rate (i.e., the number of completed home visits divided by the number of expected home visits) was 72.5.
- **Staff qualifications:** Almost three-quarters of the home visitors working in this sample of EBHV programs have bachelor or masters degrees. In terms of bilingual capacity, almost 90% of the EVHB programs operating in the collar townships and 64% of city programs employ one or more home visitors that are bilingual. Across all three community clusters, the current pool of home visitors have 5.5 to 6 years of experience providing home based interventions and 4 to 5 years invested in their current position.
- **Supervisory strategies:** The most consistent form of supervision programs provide home visitors is individual meetings in which the supervisor and home visitor discuss the worker's current caseload

and develop appropriate strategies for addressing emerging problems or challenges. On average, these types of meetings are held weekly or, at a minimum, three to four times a month.

- **Training opportunities:** A wide range of basic and enhanced training opportunities were provided EBHV programs by the Ounce of Prevention Fund's Training Institute from July 2009 through June 2010. On average, EBHV programs sent their staff to 5.8 trainings during the most recent fiscal year. In addition to the trainings offered by the Ounce, the majority of programs surveyed provided additional training options for their direct service personnel. Approximately three-quarters of all program managers responding to the survey reported offering their staff on-site training opportunities.
- **Involvement in partnerships and collaborations:** The majority of the program managers we surveyed indicated that they are involved in one or more local collaboratives around the issue of early intervention and support for new parents. Programs operating in all areas of the state are engaged with other local service providers, community residents and public agencies in building a stronger response for new parents. The most common collaboratives cited by respondents included: All Our Kids (AOK) Network, Child and Family Connections, Local Interagency Councils (LIC), and Strengthening Families.

Data Limitations

The data used to complete the needs assessment has several limitations. First, the limited time frame provided to conduct the needs assessment required us to draw extensively on administrative data sources for summarizing the distribution of risk factors and adverse child outcomes. These data come from multiple sources and cover different time periods. Such data are most useful in computing rates of given events in high density areas; estimates generated from these data are less reliable when a community has a low population base. For purposes of this study, this limitation primarily impacts our estimates of the scope of various problems in the smaller, downstate counties.

Second, our assessment of program and service quality is limited to the information we could obtain through the program manager survey. This instrument allowed us to assess several key structural elements regarding service fidelity such as model certification, staff qualifications, training and supervision, the rate of completed home visits, and involvement in statewide and local collaborative partnerships. However, we were not able to observe the delivery of services or obtain external assessments of how participants and others in the community perceive these programs. Also, our quality review is limited to the 129 programs represented in the survey. While this sample includes all or the majority of HFI, EHS and NFP sites, it is less representative of the state's PAT programs. The fact that some PAT programs do not operate during the summer months contributed to our inability to engage a more sizable proportion of PAT program managers. As such, our assessment of the current quality of the EBHV programs being delivered in the State is, at best, preliminary, particularly with respect to PAT.

Finally, we were not able to obtain complete information with respect to the specific catchment areas served by each of the existing EBHV providers nor do we fully understand all the avenues programs utilize to identify and secure their participant base. Although one might assume that home visiting programs, particularly those located in community based service agencies, might draw their participants from the local neighborhood, this is not always the case. Home visitors can and do travel some distance to provide services to families in their homes. Similarly, families may elect to seek services in adjacent communities if local service capacity is insufficient or of poor quality. A critical step in developing the State plan will be better understanding each program's catchment area and the degree to which the current distribution of programs leave certain communities or types of high risk families underserved.

Key Challenges

The best strategy for allocating funding from the Maternal, Infant, and Early Childhood Home Visitation Program is far from self-evident. This document represents an initial attempt to quantify the scope of the problem, identify those communities and populations facing high risk for poor child outcomes, and assess the current capacity of local service systems to respond to these needs. Findings from the current needs assessment as well as findings cited in the other needs assessments we reviewed underscore four major challenges in moving forward.

- **Building a More Coordinated and Robust Service Response at the Community Level:** Regardless of the communities in which it elects to focus, the state will need to pay particular attention to the capacity of local organizations within each community to implement and sustain EBHV programs with fidelity and the degree to which local service networks can offer the types of service options that will be required for these home based interventions to realize maximum impacts. Preliminary results generated through this needs assessment suggest that in many communities throughout the State local service capacity to support EBHV programs is limited. Unless improvements can be realized in the availability and quality of local services in many critical areas including basic support services as well as therapeutic services, it is unclear if expanding the availability of EBHV programs will achieve the anticipated changes in core outcomes, particularly in the highest risk communities.
- **Strengthening Infrastructure Capacity:** Both the current needs assessment and the Title V assessment suggest the need for a more concerted effort to improve the State's infrastructure around service delivery, particularly in the areas of data management and collaboration. In order to insure that home based interventions are reaching those at greatest need and providing access to the other medical, therapeutic and supportive services new parents and young children require, more accurate information is needed on current service capacity and performance. Specifically, investments in this

area would be enhanced if the State developed a single data management system that would document the characteristics of participants enrolling in these programs, their service experiences including the extent to which they need and receive additional services and support, and their initial and long term outcomes. In addition to building data capacity, it will be important to engage new partners in existing early childhood collaboratives. Both the CAPTA and Head Start assessments as well as our survey of program managers noted the importance of fostering new partnerships with agencies serving emergent immigrant populations particularly in suburban and downstate communities as well as the need to establish more formal linkages with agencies serving the homeless population and those needing emergency services to meet concrete needs.

- **Addressing Growing Population Diversity and Emerging Needs:** Developing culturally appropriate and responsive services as well as prioritizing communities and populations in greatest need of support will be increasingly difficult in Illinois. As documented in our assessment and the other needs assessments we reviewed, Illinois is home to a broad range of ethnic and cultural groups. Because the ultimate success of home visitation programs can often hinge on the ability of the home visitor to establish a strong and respectful relationship with participants, it will become increasingly important for home visitation programs to build capacity to respond to the increased diversity among the new parents they serve. At a minimum, these changes will involve hiring bilingual staff that offer proficiency in a number of languages (including Spanish, Arabic and various Eastern European and Asian languages) and developing engagement methods that can attract and retain these populations.
- **Unique Challenges of the Substance Abuse Population:** One of the most important features of the Maternal, Infant and Early Childhood Home Visitation Program is the explicit focus on the issue of substance abuse. To better identify and address the needs of this specific subgroup of pregnant women and new parents, increased investments may be needed in both systems. Areas in which capacity building might be needed include: placement of assessment counselors within existing EBHV models to facilitate the appropriate identification of substance abuse issues among those accessing these models and to develop collaborative relationships with those agencies that serve women and young children; the expansion of in-patient services for women identified with this problem within the current network of substance abuse treatment programs; and the expansion of follow-up services for women who graduate from these programs in order to facilitate the provision of appropriate aftercare services for their young children.

Overview

The Maternal, Infant, and Early Childhood Home Visitation Program included within the Patient Protection and Affordable Care Act signed by the President in March will support States in implementing evidence-based home visitation services for pregnant women and newborns and their families. The goal of these efforts is to promote early childhood health and development and, ultimately, to improve outcomes and opportunities for children and families. The specific outcomes targeted by these programs include improved maternal and newborn health; prevention of child injuries, child maltreatment and reduction in emergency room visits; improved school readiness and achievement; reduction in crime or domestic violence; improvement in family self-sufficiency; and improvements in the coordination and referrals of other community resources and support.

States seeking these dollars are required to conduct a comprehensive needs assessment for the purpose of identifying those areas of the State currently at highest risk for negative maternal and child health outcomes. As outlined in the legislation, the primary purpose of this work is to improve the capacity of the State to direct resources to those communities with the highest concentration of need and strengthen the State's overall early childhood response. Specifically, States are required to focus on two core components:

- Identifying communities with high concentration of specific social dilemmas and negative outcomes for children including premature birth, low-birth weight infants, infant mortality, particularly early death due to child maltreatment; poverty; crime; domestic violence; high rates of school drop-outs; substance abuse; unemployment; and child maltreatment.
- The quality and capacity of existing early home visitation programs, other early childhood resources and substance abuse treatment programs in the State for the purposes of determining the number of families and children being served by these efforts; existing gaps in the early childhood service system; and the extent to which these programs are effectively meeting the needs of those being served.

The Illinois Department of Human Services and Home Visit Task Force contracted with Chapin Hall to conduct the needs assessment as specified in the legislation. In completing this task, Chapin Hall staff utilized State administrative data and surveyed direct service administrators and program managers engaged in delivering evidence based home visitation programs. In addition to analyzing these data, the Chapin Hall team also conducted a careful review of the most recent Title V needs assessment, the community-wide strategic planning and needs assessment developed under the Head Start Act, and the inventory of unmet needs and current community-based and prevention focused activities under the Community Based Child Abuse Prevention Program (CAPTA). The final recommendations presented at

the end of the report reflect the finding of our own work as well as those documented in these earlier assessments.

Before presenting our primary findings, the report briefly summarizes the study's data collection methods and analytic approach. Following this section, we present an overview of the State's efforts in supporting pregnant women and newborns, including their direct service programs and policy initiatives as well as outline the key service gaps and infrastructure needs relevant to serving pregnant women and newborns and their families cited in the State's other recent needs assessments. The report then outlines key findings in four core areas:

- a profile of those communities with the highest concentration of poor child outcomes and other unfavorable social conditions;
- identify those residential areas in which the most challenged families (e.g., present multiple risk and services needs) reside;
- summarize the distribution of existing resources and evidence-based home visitation programs available for pregnant women and newborns across the State; and
- offer preliminary indications of the quality of existing programs and the extent to which local service capacity exist to meet the needs of at-risk families.

The report concludes with a list of recommendations regarding potential target populations and communities as well as general areas for infrastructure development for the State and Home Visiting Task Force to consider in crafting the state plan. This section also outlines limitations in the state's current data based and offers suggestions on how monitoring efforts of the State's overall system of home visitation and other supports for new parents might be improved.

Methodology

A central component of this effort is identifying specific communities or areas which have a high concentration of needs across multiple domains and the extent to which sufficient resources exist to address these needs. For purposes of this analysis "community" has been defined in various ways. In Chicago, we used census tracts and "neighborhood" areas that have been clearly established over time by both local residents and public service agencies. For many indicators in other areas of the state, community boundaries were established using township or county level data as defined by the types of data that were available. Although the size of the various "communities" identified in this analysis varied, useful and relevant definitions of "community" were possible for all regions of the state.

Table 1 summarizes the primary data sources for each core outcome cited in the legislation as well as our approaches for assessing service availability and quality. As indicated in this table, only two of the

elements of this study – assessing local service availability and determining service quality-- required the collection of new data. In all other cases, Chapin Hall drew on state administrative data already available to the study team through its existing data sharing agreements with various state agencies, through public use data tapes or available written material. As discussed below, our assessment of needs and concentration of high risk was limited to secondary analyses of these data.

Table 1. List of Key Outcomes and Relevant Data Sources

Indicators	**Data Sources (Year Reported)**
Child Outcomes	
Total number of births	Illinois Department of Public Health (2008)
Birth rate	Illinois Department of Public Health, Claritas (population estimates) (2007)
Poverty Indicator (Births: % Medicaid)[1]	Illinois Department of Public Health (2007)
Births: % premature	Illinois Department of Public Health (2007)
Births: % low birth rate	Illinois Department of Public Health (2007)
Births: % single parents	Illinois Department of Public Health (2007)
Births: % moms < 17	Illinois Department of Public Health (2007)
Teen birth rate (< 17)	Illinois Department of Public Health, Claritas (population estimates) (2007)
Infant mortality rate	Illinois Department of Public Health (2007)
CAN substantiated reports	Illinois Department of Children and Family Services, Chapin Hall population estimates (2009)
Crime rate	Illinois State Police (2008)
Unemployment rate	Illinois Department of Economic Security, Claritas (population estimates) (2010)
Domestic violence rate	Illinois State Police (2008)
School drop-out rate	Illinois State Board of Education (2008)
Substance abuse rate	Illinois Department of Human Services (2008-2009)
Homeless rate	State advocates/local service providers (2007-2009)
Capacity/Quality Indicators	
Program capacity	Program manager survey
Program quality	Program manager survey/assessments of state administrators
Substance abuse services	Illinois Department of Human Services/Division of Alcoholism and Substance Abuse and Division of Community Health and Prevention/other needs assessments
Mental health services	Illinois Department of Human Services/other needs assessments
Emergency services and concrete needs	Illinois Department of Children and Family Services/community directories/other needs assessments
Community health services	Illinois Department of Human Services/other needs assessments

[1] In determining an areas relative poverty rate, we have used the percent of births that were paid by Medicaid. This approach provides a more current estimate of poverty levels among the primary population of interest (i.e., families with young children).

Community Profile by Child Outcomes

We began by mapping indicators of the child and family outcomes listed in Table 1 using the most recent data available from state administrative sources.[2] Specifically, each community was initially assessed for relative risk based upon a set of demographic markers commonly associated with higher parental stress and less favorable developmental outcomes for children. These variables include such issues as birth rate, the percent of poverty among households with children; percent of households with young children headed by a single parent; teen pregnancy rate; mean educational level among adults in the community; and unemployment levels. In addition, we computed the frequency with which children or residents in each community face key challenges or experience negative outcomes such as premature births, low birth weight, infant mortality, crime, domestic violence, school drop-outs, substance abuse and child maltreatment. We created a series of maps using ArcGIS software to examine the distribution of each outcome variable in each community, township or county in the State.

Areas of Concentrated Risk

In addition to providing a general assessment of risk levels across different parts of the State, the needs assessment paid particular attention to those communities or geographic areas that demonstrate a high concentration of multiple risk factors and challenges. To address this issue we utilized an assessment strategy Chapin Hall has used in the past to determine community impacts on such issues as foster care placement and community child abuse prevention strategies. [3] Specifically, we selected a small number of indicators that we combined into a summary measure to identified those areas at highest risk. These areas were defined for three groups of communities (Chicago neighborhoods, suburban or mid-size urban counties, and rural counties). Each indicator in the scale was standardized to a scale of 0-100 within a given cluster. A community's final score is the average of the standardized values of all the indicators in the scale. Those communities with lower score are considered to be at the lowest risk while those with the highest scores are considered at highest risk. Maps using ArcGIS software were then developed to identify the highest risk communities and to identify the geographic proximity of these high risk communities to each other.

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[2] In conducting our analysis, we have utilized the most relevant and reliable data sources possible. It is important to note, however, that in some cases the most relevant data may be as much as three years old. In such cases, we explored alternative data sources or proxies for our primary indicators.

[3] Huang, L.A., Hart, B. & Daro, D. (2010). Improving Services for Pregnant Women and Children 0-1 in Central New York State: Profiling High Risk Communities. Chicago: Chapin Hall at the University of Chicago.

Chapin Hall also identified communities with the highest concentration of families with young children who have had contact with multiple state human service agencies drawing on recent work we have conducted for the Governor's Office.[4] This earlier research analyzed the experiences of families in Illinois in the adult corrections, juvenile justice, child welfare, mental health, substance abuse, and health care systems financed through Medicaid. This initial study population included all families who have been Illinois Department of Child and Family Services cases and those Illinois Department of Human Services cases which included a woman aged 18-45 years who had received food stamps between 1/1/2007-12/31/2008. In applying this methodology to the current study, we re-analyze these data to focus only on families with young children 0-5 to identify those communities in which these young families are concentrated.

Distribution, Adequacy and Quality of Existing Resources

Chapin Hall used multiple data sources to determine State-wide and local community service availability and quality. Administrative data that contributed to this analysis included program data records which provided the location of the individual program sites as well as more descriptive data on overall program capacity as documented in the most recent Title V, CAPTA and Head Start needs assessments referenced earlier. In addition to these sources, DCFS' Statewide Provider Database was used to provide additional information on those areas that have a high concentration of evidence-based practices across a range of services including substance abuse, mental health, family violence and general family support. Although these secondary data sources were limited in that they do not provide detailed information on a given program's catchment area or on the residential location of its participants, they provide a rich profile on the range and capacity of services being offered to high risk families within various parts of the state. To better define this service profile at the community level, we utilized two additional data sources – a survey of agency managers providing one or more of the State's four targeted evidence-based home visitation models and interviews with key state program directors administering these programs.

Because of the legislative focus on evidence-based home visitation services, we paid particular attention to documenting the location, service capacity and quality of each of the State's major home visitation initiatives. These include implementation of the Nurse Family Partnership (NFP); Healthy Families Illinois (HFI); Parents as Teachers (PAT); and Early Head Start (EHS). Program managers at each program were asked to provide information regarding descriptions of their current participants and staff, assessments of service capacity and quality of service resources within their service area, and the extent to

[4] Goerge, R.M., Smithgall, C., Seshadri, R., & Ballard, P. (2010). Illinois Families and Their Use of Multiple Service Systems. Chicago: Chapin Hall at the University of Chicago.

which they are currently working with other local providers to improve supports for new parents. A copy of the survey is included in Appendix A.

Based on conversations with state administrators and national model developers, a potential list of respondents was generated. This list included two NFP sites, 42 HFI sites, 25 EHS sites, and 200 PAT sites. Although we were able to secure reliable contact information for all of the NFP, HFA and EHS sites, contact information was available for only 166 PAT sites. We obtained completed surveys from both NFP sites (100%), 34 HFI sites (81%), 19 EHS sites (76%) and 72 PAT sites (43%). The lower response rate for the PAT sites reflect, in part, the fact that about half of the PAT sites only operate during the school year making it difficult to contact program managers during the summer. Indeed, 70% of those PAT sites not responding to the survey were operated by local school district personnel. Also, of the PAT sites that responded, 14 were no longer operating their program, two had suspended services, and one refused to participate.

In addition to obtaining descriptive information on individual program quality, we also interviewed the key state administrators of these programs and Federal Region 5 staff responsible for overseeing Early Head Start to obtain a general rating of the extent to which individual grantees are perceived as exceeding, meeting or falling below program standards.

The Planning Context

Statewide Collaborative History

Illinois has a long and successful history of collaboration at the state and community levels to develop, implement, support and evaluate a comprehensive system of early childhood services. Key partners in the state's collaborative efforts include:

- The Illinois Department of Human Services (IDHS): This agency is responsible for the state's maternal and child health, mental health, substance abuse, rehabilitation, developmental disability and public welfare programs (including the Child Care Assistance Program and the Head Start Collaboration Office). IDHS also operates one of the 17 Supporting Evidence-Based Home Visitation Programs to Prevent Child Maltreatment (EBHV) grants from the federal Administration for Children and Families (ACF). IDHS has used State funds for 13 years to support 42 Healthy Families America (Healthy Families Illinois, HFI) home visiting programs. The Federal home visitation initiative will further strengthen these investments by ensuring that new and expanded home visitation programs are fully integrated with IDHS' other maternal, infant and early childhood programs, including Family Planning, Family Case Management, Healthy Start, WIC, Part C of IDEA and others.

- The Illinois State Board of Education (ISBE): This agency provides funds for public education preschool through grade 12. Illinois is a recognized leader in early childhood education programs, including Preschool for All, a universal preschool education program for 3- and 4-year-olds, and the Prevention Initiative, which supports evidence-based parenting education and child development services to high risk families with children under age three through center- and home-based programs. Preschool for All sites are located in a variety of settings, including public schools, child care centers, faith based organizations, higher education institutions, park districts and Head Start centers. Through the Prevention Initiative, ISBE uses state funds to support 156 Parents as Teachers programs, partners with IDHS to jointly fund two HFI programs and provides partial support for both of Illinois' Nurse-Family Partnership (NFP) programs. Within the city of Chicago, the Chicago Public Schools (CPS) play a major role in facilitating the implementation of ISBE early childhood investments. The Office of Early Childhood Education (OECE) partners with community agencies in Chicago to provide high quality preschool to 3- and 4-year-olds and Prevention Initiative services to at-risk children age birth to 3 and their families.
- The Illinois Department of Children and Family Services (DCFS): As the state's child welfare agency, DCFS is responsible for the administration of Title IV-e, Title II (Child Abuse Prevention and Treatment Act, CAPTA) and the Community-Based Child Abuse Prevention Program (CBCAP) from the Federal ACF.
- The Illinois Head Start and Early Head Start Agencies: This network serves nearly 40,000 low income children. All pregnant women and most children under age three who are served in Head Start/EHS are served in comprehensive home-based programs. Nearly 1,000 Head Start children ages 3-5 years are in the home-based program option. Head Start home-based programming consists of evidence-based curricula, child screening and ongoing assessment - both developmental and health - as well as nutrition, mental health, family partnership building, case management, and community partnership components.
- The Ounce of Prevention Fund: This agency has been in the vanguard of collaborative early childhood system development in Illinois since 1993. Beginning with the Birth To Three Project with financial support from the Robert Wood Johnson Foundation, followed by the Birth To Five Project supported by the Early Childhood Funders Collaborative and finally with the Early Learning Council (which has been established in state law), the Ounce has convened hundreds of public and private sector professionals, academics, advocates and parents to shape Illinois' early childhood system. The Ounce has also worked closely with IDHS and its predecessors in the development of 21 Parents Too Soon (PTS) programs, which use home visiting and other approaches to serve teen and young adult parents. Eleven of the PTS programs use the Healthy Families America model, nine use the PAT

model and one uses the NFP model. The Ounce also operates the Birth-To-Three Institute, which trains PTS, PAT, and HFI program staff. The Ounce also serves as the state office for PAT.

In 2003, the Illinois General Assembly established the Illinois Early Learning Council (ELC) in state statute to guide the development of a statewide early childhood education and care system to ensure that young children at risk for school failure and their families experience high quality programming and services necessary for children's healthy development. The ELC has a broad vision to ensure that all children in Illinois start school safe, healthy, eager to learn, and ready to succeed. In Fall 2009, at the recommendation of the ELC, the Governor created the Office of Early Childhood Development (OECD) within the Governor's Office. The role of the OECD is to strengthen Illinois' efforts to establish a comprehensive, statewide system of early childhood care and education. The OECD coordinates and guides the work of the ELC and collaborates with state and federal agencies on implementation of ELC recommendations. The OECD, along with its non-profit partners, provides staffing support to the full ELC and its committees.

In 2008, the ELC created the Home Visiting Task Force (HVTF) under its auspices to support the development of one coordinated, high-quality system of home visiting programs that will reach all at-risk children under five years of age. To move Illinois towards that vision, the long-term goals of the Task Force are to expand access to evidence-based home visiting programs for all at-risk children; improve the quality of home visiting services; and increase coordination between home visiting programs at the state and local level, as well as between home visiting and all other publicly-funded services for mothers, infants and toddlers. The Task Force is comprised of a diverse group of stakeholders, including representatives from national home visiting models, statewide administering agencies, program providers, researchers, parents, and advocates.

The Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program will enable Illinois to consolidate and build upon the work begun through EBHV and further develop its system of home visitation programs through the expansion of existing programs and the establishment of new ones, as directed by the needs assessment.

The HVTF, led by its Executive Committee, will serve as the convening, policy-setting, and decision-making body for the state's implementation of this effort.

Related Needs Assessments

Our current effort builds on information obtained through recent needs assessments conducted by the State in response to other Federal programs which involve services to pregnant women, young children, and children at risk of maltreatment. Specifically, our data collection methods took into account the

findings and recommendations documented in the State's most recent Title V needs assessment, the community-wide strategic planning and needs assessment developed under the Head Start Act, and the inventory of unmet needs and current community-based and prevention focused activities under the Community Based Child Abuse Prevention Program (CAPTA). This section summarizes key strengths and concerns highlighted in these documents.

Title V Needs Assessment

The Illinois Department of Human Services (IDHS) and the University of Illinois at Chicago's Division of Specialized Care for Children (DSCC) conducted the Title V needs assessment for inclusion in the State's FY2011 Maternal and Child Health Services Block Grant application. Initiated in January 2009, this 18-month process was spearheaded by a workgroup of administrators, epidemiologists and data analysts from IDHS and DSCC. An Expert Panel comprised of 11 health care professionals was tasked with providing input into the needs assessment process, reviewing data and selecting MCH priorities. In addition to the public hearings and deliberations held by the Expert Panels, input was sought from providers and consumers through a series of community forums and focus groups. Quantitative data available from state administrative records and other surveys were used to provide a descriptive profile of the state and highlight the state's relative performance on key health system capacity and health status indicators.

Findings of particular relevance to this effort relate to the service availability and performance trends regarding the health of mothers and young children. Overall, the Title V needs assessment observed modest to no improvement in recent years on a number of key morbidity and mortality indicators, despite the expansion of key services. Although almost all of Illinois infants have access to health coverage, rates of infant mortality and low birth weight remain well above the national Healthy People objectives. Compared to other states, Illinois ranks 13th in the child-death rate, 26th on immunization rates, and 42nd on dental sealants. Similarly, the percentage of pregnant women accessing early pre-natal care (in the first trimester) and the percentage receiving an adequate number of pre-natal visits fall below the recommended Health People 2010 objectives. As is true nationwide, significant disparities in health care status for pregnant women and young children exist throughout the state. The black-white gap is persistent on many indicators and disparities by income and insurance status also are common.

Information obtained from the community, provider and consumer forums suggest the need for increased communication at both the state and community levels. Local providers noted the need for increased networking opportunities among all MCH programs and for improved outreach and education to local providers. Of particular importance was the need for more integrated data systems and electronic medical records that would facilitate the ability of local providers to access important information on their

program participants. On the consumer side, families expressed the need for more timely and complete information regarding service eligibility requirements, application procedures and service locations. Consumers also noted the need for more respectful and culturally competent service providers and administrators.

Drawing on the full range of data and input received during the Title V needs assessment process, the Expert Panel, in partnership with state leaders, identified ten priorities for the coming year. The priorities include the following:

- Improve Title V's capacity to collect, acquire, integrate/link, analyze, and utilize administrative, programmatic and surveillance data.
- Integrate medical and community-based services for MCH populations and improve access to these services, particularly for children with special health needs.
- Promote, build and sustain healthy families and communities.
- Expand availability, access to, quality and utilization of medical homes for all children and adolescents, including children with special health needs.
- Expand availability, access to, quality, and utilization of medical homes for all women.
- Promote healthy pregnancies and reduce adverse pregnancy outcomes for mothers and children.
- Address the oral health needs of the MCH population through prevention, screening referral, and appropriate treatment.
- Address the mental health needs of the MCH population through prevention, screening, referral, and appropriate treatment.
- Promote healthy weight, physical activity and optimal nutrition for women and children.
- Promote successful transition of youth with special health care needs to adult life.

As a group, these recommendations are reflective of the focus of the home visitation legislation, particularly as it relates to the importance of building infrastructure support around data management and service coordination and collaboration to facilitate the implementation of evidence based programs and practices. Also, the expansion of home based interventions for pregnant women and new parents offer an important strategy for insuring early and consistent access to pre-natal care, early identification of a medical home for newborns, and improved access to mental health services and services for children with special medical problems.

Community Based Child Abuse Prevention Program (CAPTA) Annual Needs Assessment

The key Federal legislation addressing child abuse and neglect is the Child Abuse Prevention and Treatment Act (CAPTA), originally enacted in 1974 (P.L. 93-247). This Act was amended several times and was most recently amended and reauthorized on June 25, 2003, by the Keeping Children and Families

Safe Act of 2003 (P.L. 108-36). Title II of the act provides funds to a designated lead entity in each state for support and development of community-based programs and activities that prevent child abuse and neglect. The legislation requires the lead agency to conduct an inventory of unmet prevention service needs in the state, to foster a continuum of family support and strengthening services at the community level, to leverage non-federal funds to support prevention programs and activities and to provide technical assistance to funded community based groups. In Illinois, the lead agency is the Department of Children and Family Services (DCFS). Although DCFS does not support regular, large-scale statewide needs assessments, information relating to unmet needs is collected on an ongoing basis through several sources. First, each grantee supported through the CBCAP funds or match funds is asked to delineate any unmet needs within their communities on an annual basis. Second, the State has utilized findings from the United Way's Comprehensive Community Needs Assessment to determine service availability and quality across the state. Finally, regular surveys are conducted of the State's Local Area Networks (LANs) coordinators as well as child welfare staff for purposes of flagging emerging needs and service shortfalls.

The most recent of these survey efforts identified a number of consistent issues across the State regarding the availability of key services and the quality of these services. Specifically, critical shortages were noted in the following areas:

- individual and family counseling services for children and adults;
- domestic violence counseling;
- transportation services and bus tokens for clients to facilitate access to scheduled appointments;
- ethnic specific therapists and counselors; and
- in-patient substance abuse treatment

There are wait lists from one month to one year for all types of mental health services, domestic violence services, and in-patient substance abuse treatment. These patterns are particular of concern given the extent to which home-based interventions often rely on the availability of these resources to augment their work with parents presenting difficulties in these domains.

Repeated feedback from coordinators of the LANs throughout the State cite several major challenges in meeting the needs of young children and their families, in addition to the shortage of key ancillary services. First, the state is experiencing an increasing influx of immigrants. Although Chicago has long been home to a significant number of new and second generation immigrants, all regions of the State now report pockets of immigrant communities, many of which include a notable proportion of non-English speaking families. Greater ethnic diversity is reported in many areas in suburban Cook County and counties surrounding the city as well as in the central and southern regions of the State. Providers serving

these populations are struggling to hire bilingual staff and to identify culturally appropriate practices that will successfully engage these families in preventive services. In addition, the influx of new populations can create tensions within the fabric of community life, as residents, as well as providers, adjust to families and cultures that can represent different parenting practices and normative expectations regarding social interactions.

Second, the State's rural communities face key shortages in all service domains, shortages that are becoming more pronounced in light of recent state budget cuts. Infants and new parents living in the central and southern parts of the state who need more specializes health care and social services have to travel long distances to find these resources. Those providing home based interventions have to contend with a participant population that may span large geographic areas making it difficult for a provider to see more than one or two families a day. As with other areas of the country, the production and use of methamphetamines continues to present a significant challenge in many rural communities throughout the State.

Finally, the economic downturn and high unemployment rates throughout the state are creating an increased demand for a range of basic care services. Demands for housing assistance, affordable child care, and emergency services are an increasingly common request among families. Several of the LANs coordinators note that pockets of poverty and high need are emerging within suburban and other communities generally perceived as having only affluent residents. Parents of infants and young children that are new to the ranks of the unemployed often find it difficult to ask for assistance and may not be familiar with the range of publicly provided health care and family support services.

Each of these issues has implications for the State's plan to expand home visitation services for pregnant women and new parents. The increased diversity in the population may require program models to make adjustments in the content of their curriculum and current outreach efforts. Greater understanding may be needed in how to introduce services to these parents and their extended family members. New partnerships may need to be developed with community services agencies and non-profits that target a wide range of immigrant groups. The emergence of new "pockets of poverty" in affluent communities may suggest the need for program expansion in communities traditionally viewed as lower risk. Introducing public services in such communities as well as engaging families unfamiliar or perhaps uncomfortable in asking for assistance may require a reassessment of how the home based interventions are presented to this subgroup of pregnant women and new parents. Finally, expanding home based interventions in the State's rural communities may require the identification or testing of new services that take into account the geographic challenges and limited service options presented by low density communities.

Collaborative Needs Assessment Strategic Plan 2009-2015, Head Start Collaborative Office

The purpose of the Head Start State Collaboration Office (HSSCO) is to facilitate collaboration among Head Start agencies and entities that carry out activities designed to benefit low income children from birth to school entry and their families. The collaboration needs assessment addressed the needs of Head Start agencies with respect to collaboration, coordination and alignment of services. The most recent needs assessment conducted by the HSSCO assessed the collaborative partnerships agencies had formed with others around the following domains: health, services for children experiencing homelessness, welfare, child welfare, child care, family literacy, children with disabilities, community services, education and professional development.

Between December 2008 and March 2009, the Illinois HSSCO and the Illinois Head Start Association conducted a web-based collaboration needs assessment survey of all Head Start grantee agencies in Illinois. In each of the study's priority areas, the survey assessed both the *depth* of the working relationship the Head Start agencies reported with providers within a given domain and the *difficulty* associated with establishing and sustaining these relationships. The depth of the relationship was measured on a four-point scale – no working relationship (little or no contact); cooperation (exchange of information and referrals); coordination (working together on specific tasks); and collaboration (shared resources and formal working agreements). The level of difficulty in establishing and sustaining the relationships in each domain ranged from not at all difficult, to somewhat difficult, to difficult, to extremely difficult. Results were examined statewide, by geographic categories, and a separate section was completed for Migrant and Seasonal Head Start. An interdisciplinary planning group developed a strategic plan to respond to the findings and to coordinate these efforts with the work of Illinois' other statewide system building groups.

Although Head Start agencies frequently share information and engage in joint activities with other local providers in most of the domains that were assessed, formal collaboration is rare. As might be expected, the strongest relationships exist with local education agencies around issues of transition and alignment with K-12, other child care providers and health agencies. Weaker relationships were found with local community service agencies, those offering disability services and those addressing homelessness. On average, the difficulty in developing and sustaining these relationships ranged from 1.56 (community services) to 1.92 (homelessness) on a four point scale, suggesting a general openness to working collaboratively at the local level but a relationship which presents some challenges.

In reflecting on these findings, the following recommendations were cited as promising strategies for improving the quality of care for families with young children:

- improving the capacity to link families to medical and dental homes;

- improving outreach and engagement with state homeless organizations;
- implementing systems that connect all Head Start grantees to state level collaboration and planning efforts;
- engaging economic and development councils, employment, training and labor agencies and TANF with Head Start providers;
- assessing the current alignment across various practice issues found among all early childhood providers;
- linking Head Start agencies with family literacy providers and resources;
- strengthening accessibility to culturally and linguistically appropriate services across priority areas;
- working with all state and local partners to improve the timeliness of evaluations for children presenting developmental delays;
- increasing the implementation of MOUs between Head Start and other pre-K initiatives and providers;
- continuing to increase professional development resources and articulation of coursework; and
- continuing to develop local community collaborative councils.

As with the other two needs assessments, the findings from this assessment raise important factors to consider in expanding home based interventions. First, the findings underscore the importance of access to early and stable medical care for young children as a strategy to support positive early development. Home visitation programs that engage pregnant women or new parents shortly after birth provide a promising vehicle for introducing the importance of a medical home and establishing this linkage. Second, the emphasis on establishing collaborative relationships with agencies addressing the needs of homeless families flag an important, and often overlooked, subpopulation. Effectively meeting the early learning needs of children whose families do not have permanent housing represents a significant challenge for home visitation models. New protocols may need to be established to guide the delivery of core content and to insure adequate engagement and retention of these families. Finally, strengthening the depth and quality of the partnerships home based interventions form with local providers addressing myriad issues will be essential in order to achieve change in the core outcomes identified in the legislation. No single intervention, no matter how well defined and carefully implemented, can address the diverse needs presented by high risk families. Achieving meaningful impacts will require strong and consistent relationships with other local providers addressing issues of health, mental health, welfare, disabilities, and education.

The Findings

This section of the report presents the specific findings from our needs assessment. We begin with a general discussion of the risk factors and challenges facing new parents across the State. For many of the child and community risk factors identified in the legislation, we were able to track the rate or frequency of these issues at the community or sub-state level. Unfortunately, reliable community-level estimates for two the indicators – substance abuse and homelessness – were not readily available. As such, this section of the report pays particular attention to these two issues. Following this discussion, we examine the distribution of risk across different areas of the state and identify those areas of highest risk. We have identified high risk communities in three specific areas of the state – within the city of Chicago, within the township and suburban communities surrounding the city, and counties across the balance of the state. Following this presentation, we then present a general overview of where the State is currently investing in evidence-based home visitation models and examine the capacity and quality of these and other related services. Individual sections are presented on the overall distribution of home visitation services and substance abuse treatment programs across the state, key capacity issues among the current pool of evidence based home visitation services, and indicators of quality among these programs.

Critical Risk Factors and Challenges

Although we cannot accurately estimate the frequency with which young children and their families experience substance abuse and homelessness at the community level, we were able to draw on a wide range of socio-economic and health outcomes to create robust risk profiles for individual Chicago neighborhoods, the surrounding suburban communities, and counties throughout the balance of the state. The relative risk of children experiencing poor birth outcomes and other negative conditions in their early years varies across the state, with virtually every community including a subset of families that will face one or more challenges in meeting their children's needs. As summarized in Table 2, wide variation existed in the level of distress found in communities across the state on all of the indictors we were able examine at the community level. In 2008, 176,634 babies were born in Illinois, roughly 5% fewer than the number of infants born in the state in 2000. Of these births, almost two-thirds were born to families living in Chicago or the surrounding suburban communities. Reflecting this pattern, the birth rate in Chicago neighborhoods is higher than elsewhere in the state, with 73.5 births per 1,000 females ages 15-44 in Chicago versus 55.4 births per 1,000 females ages 15-44 in the counties outside the metropolitan area. Also, children born in Chicago were more likely born into poor families, with Medicaid covering almost 63% of these births. In contrast, only a third of the births to families in the areas surrounding Chicago were covered by Medicaid as were slightly more than half of the births in the balance of the state. In the area of health outcomes for young children, children living in the city of Chicago are more likely than

infants in other parts of the state to be born to a teen parent, to have a low birth weight and to die during their first year of life. Those that do survive and enter school are at significantly higher risk than youth in the collar counties and downstate to drop out of school. This profile is consistent with how others have described the challenges facing young children living in the city's most distressed communities.

Table 2. Relative Risk by Community Cluster

Indicator	Definition	Chicago Community Areas	Townships in Cook and Collar Counties	Balance of State Counties
Birth rate	# live births per 1,000 females 15-44	73.5 (17.5)	62.1 (22.9)	55.4 (15.1)
Births: % Medicaid paid	# births Medicaid covered/all births	62.8 (24.2)	33.6 (19.4)	58.7 (14.2)
Births: % premature	# live births <37 weeks/all live births	11.7 (3.7)	10.1 (4.0)	9.8 (3.4)
Births: % low birth weight	# live births <2,500 grams/all live births	10.4 (4.7)	7.3 (2.9)	7.6 (2.8)
Births: % single mothers	# births to single parents/all births	52.9 (26.1)	26.2 (14.8)	40.1 (9.8)
Births : % moms < 17	# to teens <17/ all births	5.0 (3.2)	2.0 (2.1)	3.5 (3.4)
Teen birth rate (< 17)	# teen births per 1,000 females 10-17	13.8 (8.6)	4.8 (6.0)	6.9 (4.4)
Infant mortality rate	# infant deaths 0-1 per 1,000 live births	9.5 (8.8)	5.3 (11.0)	5.2 (5.2)
CAN substantiated reports	# indicated CAN victims 0-5 per 1,000 pop. 0-5	9.1 (7.0)	7.0 (6.0)	21.2 (8.7)
Crime rate	# crime arrests per 100,000 pop.	--	559.9[a] (176.7)	609.5 (344.7)
Unemployment rate	# unemployed and seeking work/ total work force	11.9 (7.4)	10.3[a] (0.8)	10.2 (1.7)
Domestic violence rate	# of DV incidence per 100,000 pop	--	454.2[a] (382.1)	481.3 (554.9)
School drop-out rate[b]	% of 9th grade cohort who did not graduate in 4 years	12.5 (5.6)	1.8 (1.7)	2.5 (1.2)
N		77	114	96

Mean for cluster (standard deviation)
[a]Average of county-level rates (N=6).
[b]Based on location of school, not student residence.

In other domains, however, relative risk is more uniform across the state, although on balance less risk was observed on all measures in the townships in Cook and the surrounding counties of DuPage, Kane, Lake, McHenry, and Will, than in the city or balance of the state. Indicators in which risk levels were relatively comparable across all community clusters we examined included the proportion of premature

births and the unemployment rate. In terms of premature births, about 12% of all babies born in the United States each year are premature, a rate somewhat higher than what we observed across all three community clusters. Of the three clusters, the rate of premature births was lowest in the counties outside the Chicago metropolitan area, although rates in both Chicago and the collar counties were below the national figure. In terms of the unemployment rate, the average rate in all three community clusters was 10% or higher, slightly above the current national rate.

On several other indicators, including crime and domestic violence rates, the frequency of these events as documented by the state police department was highest, on average, in communities outside the greater Chicago metropolitan area. Similarly, children 0-5 living in counties outside the immediate Chiago area were more than twice as likely to experience a substantiated report of child abuse than children living in the city. Overall, some 9 per 1,000 children 0-5 living in Chicago were identified as victims of child abuse and neglect as compared to about 21 per 1,000 children 0-5 living in the balance of the state. This pattern could reflect several trends. As noted in our review of the other needs assessments conducted in the state, methamphetamine use is a growing problem in the central and southern regions of state. These behaviors may be placing a significant number of young children at risk and resulting in increased reporting rates. Although we did not examine the rate of foster care placements for purposes of this report, other work Chapin Hall has completed has documented the dramatic caseload changes occurring within DCFS since the mid 1990's.[5] Both the number of entries to and exits from foster care have dropped, with a more dramatic decline occurring within Chicago. Not only has this resulted in an overall decline in the number of children in foster care each year, but the proportion of cases served in downstate communities now equals or exceeds those in Chicago.

Substance Abuse Problem

In addition to poverty, poor health outcomes and various indicators of violence and family distress, a growing number of children in Illinois are touched by substance abuse. As noted in several other needs assessments, Chicago is a major transportation hub and distribution center for illegal drugs throughout the Midwest and the city's gangs control the distribution and retail sale of cocaine, heroin and marijuana. Although the exact number individuals who use drugs is difficult to estimate, all areas of the state are affected. The Illinois Police Department report that crack cocaine and heroin are the most serious drug problem in Chicago while methamphetamines is a growing problem in the central and southern regions of state. During 2006, state and local police made 112,368 arrests for drug offenses, the majority of which

[5] Goerge, R. (2009). The Child Welfare System in Illinois, 1977 – 2008. Available at: http://www.state.il.us/DCFS/library/com_communications_pr_Feb82010.shtml

reflect violations of the Cannabis Control Act (45% of all arrests) or the Controlled Substances Act (39% of all arrests). According to the National Surveys on Drug Use and Health, a total of 294,000 Illinois citizens (12 years or older) reported illicit drug dependence or abuse within the past year, of which 199,000 reported illicit drug dependency. [6] The number of pregnant women and new parents directly dealing with substance abuse problems is difficult to estimate. The Division of Alcohol and Substance Abuse (DASA) reported serving 1,403 pregnant women in treatment centers last year but believe many women go undetected and, therefore, unserved. The number of child welfare cases involving a substance exposed infant (SEI) peaked in the early 1990's at roughly 8 percent of all indicated reports. The number of SEI cases has consistently declined since then, with 911 such cases – or 2.9 percent of indicated reports – in 2008. Despite that decline, the most recent DCFS child and family service review statewide assessment suggests that the number of DCFS involved parents being served for substance abuse issues is far greater. Since 1999, a collaborative initiative between DASA and DCFS provides identification of AODA issues by DCFS and private child welfare staff. In fiscal year 2000 DASA reported providing AODA treatment services to over 11,000 DCFS clients.7

Issue of Homelessness

Once thought to be largely a problem related to substance abuse, homelessness is increasing becoming an issue that touches the lives of young children. National statistics indicate that the number of homeless families has increased 30 percent since 2007.[8] Those families represent 12,525 homeless students in the Chicago Public School system alone (an 18 percent increase over the 2007-2008 school year) and an estimated 60,000 students statewide. Families make up 46.5 percent of Chicago's homeless population, including 24,022 children. [9] This indicates that only about half of Chicago's homeless children and their parents have access to school-based programs and resources. And, as noted in both the CAPTA and Head Start assessments, homeless families present unique challenges for programs focusing on parent-child attachment and infant development. The instability of these families and the immediate need to secure

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[6] Substance Abuse and Mental Health Services Administration. (2007). *State Estimate of Substance Use from the 2004-2005 National Surveys on Drug Use and Health*. (Washington D.C.: SAMSA)

[7] Source: http://www.state.il.us/DCFS/docs/swafinal.pdf

[8] U.S. Department of Housing and Urban Development, *The 2009 Annual Homeless Assessment Report to Congress* (2009), HUD.gov, http://www.huduser.org/portal/publications/pdf/5thHomelessAssessmentReport.pdf (accessed September 1, 2010), p. 30.

[9] Chicago Coalition for the Homeless. "Frequently Asked Questions about homelessness." http://www.chicagohomeless.org/learn/what (accessed September 1, 2010).

permanent and affordable housing can, at times, make it difficult for parents to focus on what may be perceived as more distal objectives.

Identifying High Risk Communities

To better understand those areas of the state which have high concentrations of multiple risk factors, we developed two summary indicators and compared a community's relative risk on each measure to other communities with similar levels of density and urbanization. This approach allowed us to develop a more nuanced identification of relative risk than would have been possible had we considered all of our "communities" together. High density urban communities often represent a state's highest area of need due to the high concentration of poverty, community violence, and other indicators of socio-economic stress typically found in inner city neighborhoods. Assessment strategies that compare these high density communities to those with fewer residents or communities with greater diversity in terms of their socio-economic composition generally focus resources on the high density urban areas. However, as discussed in the previous section, young families living in many suburban and rural areas also face significant challenges. By comparing the conditions in these communities to other areas that share similar levels of density and size, we are able to identify additional communities that may benefit from a more careful examination of their needs and service capacity.

It should be noted, however, that wide variation exists in the size and population density among those counties outside the Chicago metropolitan area. For example, the numbers of children 0-5 in these counties range from a high of over 25,000 in Winnegabo County to 258 in Hardin County. In addition, some of the counties, such as Champaign and De Kalb, are home to large universities while others have no population centers over 5,000. As such, the ability to draw direct comparisons regarding the early childhood needs and scope of the problem within this cluster is more limited. This initial review, however, does provide an accurate assessment of those areas of the state in which the concentration of problems or risk factors is greater, although the number of children impacted by these conditions will be relatively small in some of these areas. Determining appropriate investments in downstate communities will require a more nuanced examination of the data than has been possible within the scope of this initial assessment effort. Our first summary measure identified those areas of the state which demonstrated the highest risk in multiple domains. Risk indicators were selected based on the degree to which they represented variability across communities and provided a unique indicator of relative risk. In instances in which indicators were highly correlated, as in the case of Medicaid eligibility and teen parent status, for example, we selected only one of these indicators. The indicators used in this scale and our assumptions are as follows:

- Birth rate – communities with a higher birth rate were considered as having a larger number of families who might potentially benefit from early intervention services;
- % of births Medicaid eligible – communities with a greater proportion of births paid for by Medicaid were areas with a higher concentration of poor families with young children;
- Low birth weight – communities with higher rates of low birth weight infants were considered communities with potentially higher negative health outcomes for children;
- % of births to single parents – communities with a high proportion of births to single mothers were considered to have a concentration of households facing added stress; and
- Rate of substantiated cases of child abuse and neglect—communities with higher rates of confirmed maltreatment involving young children were considered as having a greater number of families needing supportive services.

A community's individual score on each indicator was standardized on a scale from 0-100 within each community "cluster" (i.e., city neighborhood, township or county). A community's final score on this measure is the average of its standardized values across all five indicators.[10] In our sample of communities, scores on this measure ranged from a low of 4.9 to a high of 82.0.

Figures 1 to 3 present the distribution of this scale across our sample communities. For each cluster, communities were divided into four quartiles based on the range of risk observed within the cluster. Communities that have the darkest shade of red represent those areas in the highest quartile (the top 25%) within their cluster in terms of their birth rate, poverty level, low birth weight rate, rate of single parenthood, and substantiated child maltreatment rate. Among Chicago neighborhoods (Figure 1), the majority of the high risk communities are located on the city's west and south side. In the townships surrounding the city (Figure 2), areas of concentrated risk are found in all of the collar counties, with contiguous pockets being observed in northeastern McHenry County, western Lake County, the western and southern portions of Cook County, and the northeastern and western portion of DuPage County. In the balance of the state (Figure 3), concentration of high risk was found across the State with contiguous counties of high risk found in the central and southern parts of the state and in the Rock Island area.

[10] The five indicators we selected for the risk index performed well with alpha scores of .84 in the Chicago community sample; .72 in the township sample; and .45 in the county sample.

Figure 1

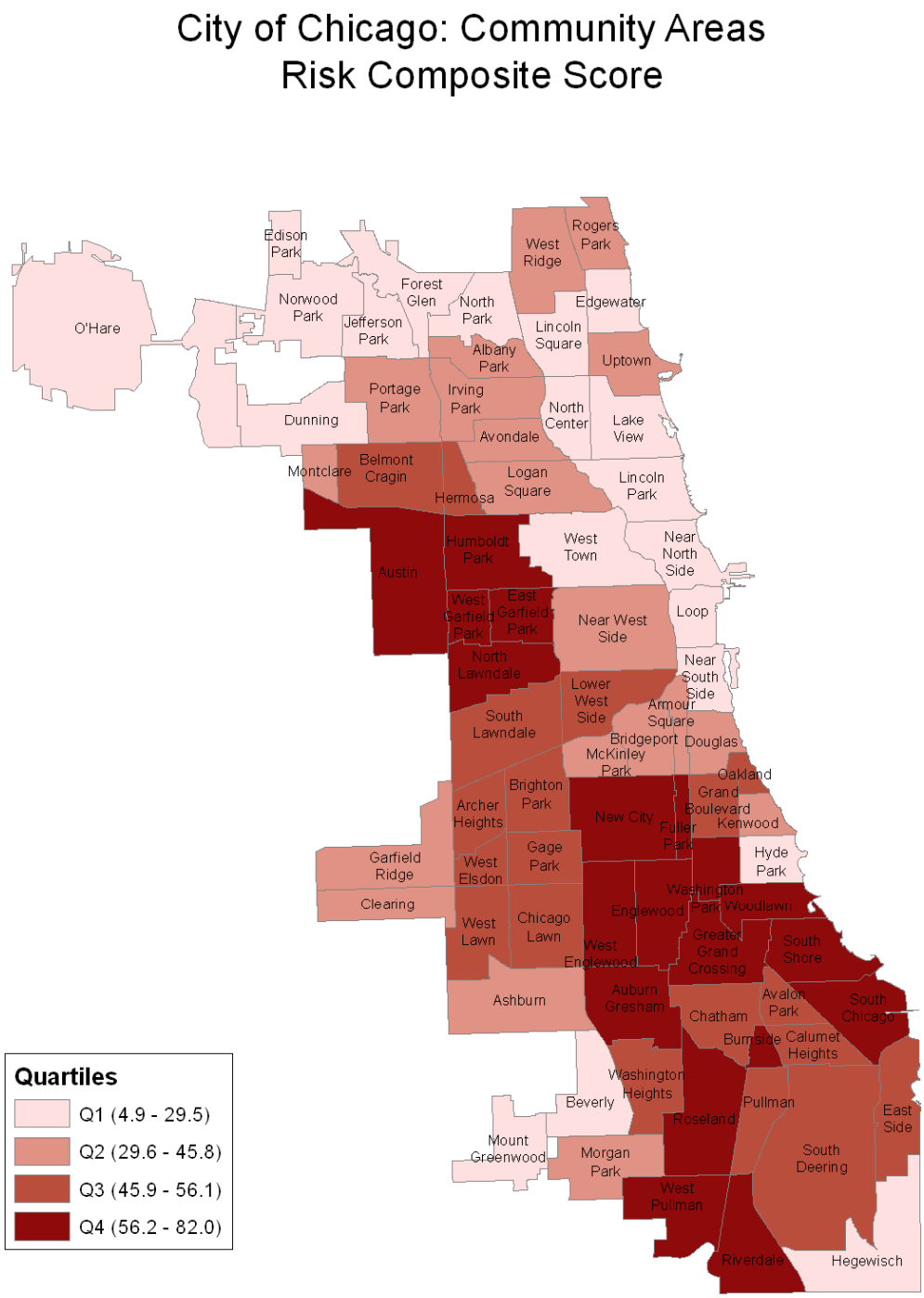

City of Chicago: Community Areas
Risk Composite Score
Edison Park
Rogers Park
West Ridge
Norwood Park
Forest Glen
North Park
Edgewater
O'Hare
Jefferson Park
Lincoln Square
Albany Park
Uptown
Portage Park
Irving Park
Dunning
North Center
Lake View
Avondale
Montclare
Belmont Cragin
Logan Square
Lincoln Park
Hermosa
Humboldt Park
West Town
Near North Side
Austin
West Garfield Park
East Garfield Park
Near West Side
Loop
North Lawndale
Near South Side
Lower West Side
Armour Square
South Lawndale
Bridgeport
Douglas
McKinley Park
Oakland
Brighton Park
Grand Boulevard
Archer Heights
New City
Kenwood
Fuller Park
Garfield Ridge
West Elsdon
Gage Park
Hyde Park
Washington Park
Clearing
Englewood
Woodlawn
West Lawn
Chicago Lawn
Greater Grand Crossing
South Shore
West Englewood
Ashburn
Auburn Gresham
Avalon Park
South Chicago
Chatham
Burnside
Calumet Heights
Washington Heights
Beverly
Pullman
East Side
Roseland
Mount Greenwood
Morgan Park
South Deering
West Pullman
Riverdale
Hegewisch
Quartiles
Q1 (4.9 - 29.5)
Q2 (29.6 - 45.8)
Q3 (45.9 - 56.1)
Q4 (56.2 - 82.0)

Figure 2

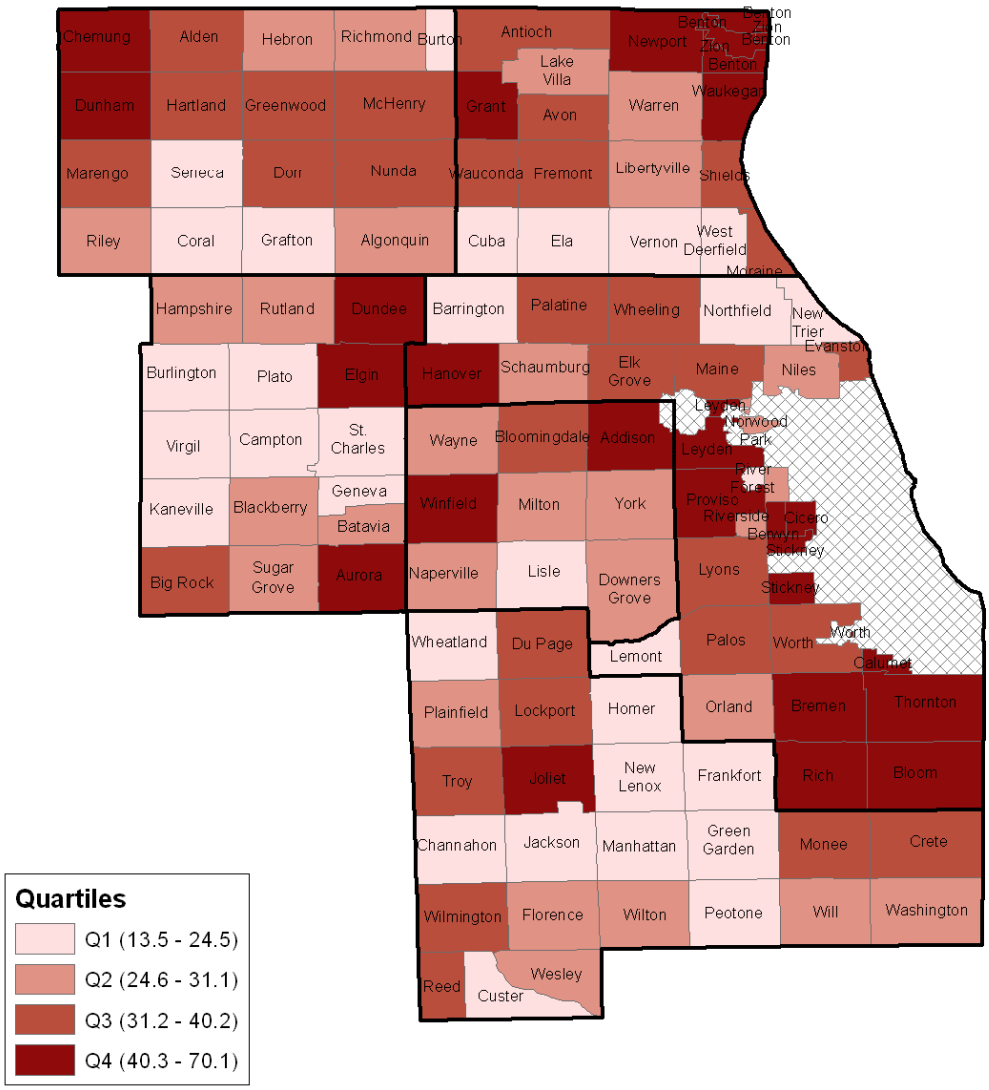
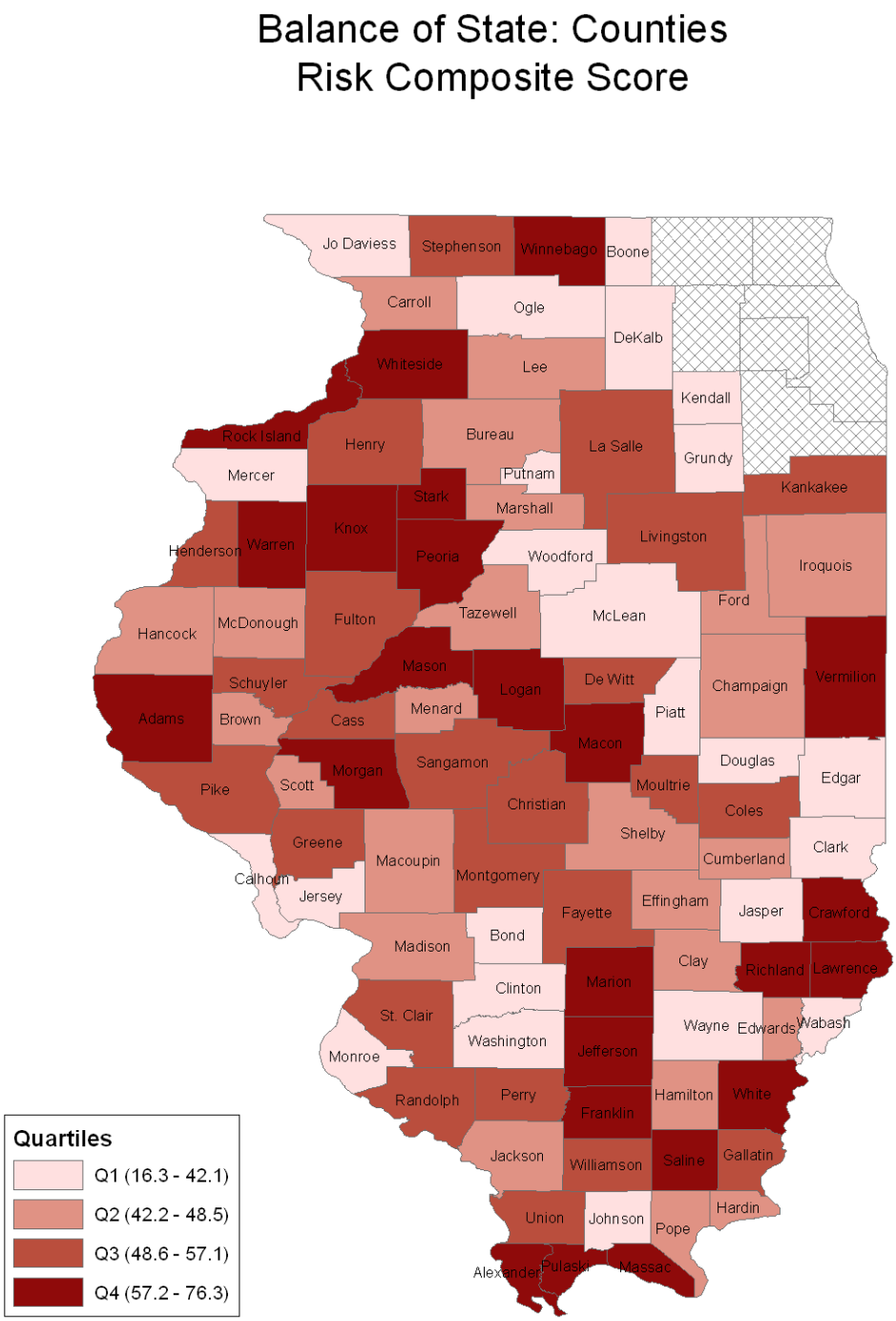

Cook and Collar Counties: Townships
Risk Composite Score
Chemung
Alden
Hebron
Richmond
Burton
Antioch
Newport
Benton
Zion
Lake Villa
Grant
Avon
Warren
Waukegan
Dunham
Hartland
Greenwood
McHenry
Marengo
Seneca
Dorr
Nunda
Wauconda
Fremont
Libertyville
Shields
Riley
Coral
Grafton
Algonquin
Cuba
Ela
Vernon
West Deerfield
Moraine
Hampshire
Rutland
Dundee
Barrington
Palatine
Wheeling
Northfield
New Trier
Evanston
Burlington
Plato
Elgin
Hanover
Schaumburg
Elk Grove
Maine
Niles
Leyden
Norwood Park
Virgil
Campton
St. Charles
Wayne
Bloomingdale
Addison
River Forest
Kaneville
Blackberry
Geneva
Batavia
Winfield
Milton
York
Proviso
Riverside
Cicero
Berwyn
Stickney
Big Rock
Sugar Grove
Aurora
Naperville
Lisle
Downers Grove
Lyons
Wheatland
Du Page
Lemont
Palos
Worth
Calumet
Plainfield
Lockport
Homer
Orland
Bremen
Thornton
Troy
Joliet
New Lenox
Frankfort
Rich
Bloom
Channahon
Jackson
Manhattan
Green Garden
Monee
Crete
Wilmington
Florence
Wilton
Peotone
Will
Washington
Reed
Custer
Wesley
Quartiles
Q1 (13.5 - 24.5)
Q2 (24.6 - 31.1)
Q3 (31.2 - 40.2)
Q4 (40.3 - 70.1)

Figure 3


Balance of State: Counties
Risk Composite Score
Jo Daviess
Stephenson
Winnebago
Boone
Carroll
Ogle
DeKalb
Whiteside
Lee
Kendall
Rock Island
Henry
Bureau
La Salle
Grundy
Mercer
Putnam
Kankakee
Stark
Marshall
Knox
Livingston
Henderson
Warren
Peoria
Woodford
Iroquois
Hancock
McDonough
Fulton
Tazewell
McLean
Ford
Mason
Vermilion
Schuyler
Logan
De Witt
Champaign
Adams
Brown
Cass
Menard
Piatt
Macon
Douglas
Edgar
Pike
Scott
Morgan
Sangamon
Moultrie
Christian
Coles
Shelby
Greene
Clark
Macoupin
Cumberland
Calhoun
Jersey
Montgomery
Effingham
Jasper
Crawford
Fayette
Madison
Bond
Clay
Richland
Lawrence
Clinton
Marion
St. Clair
Wayne
Edwards
Wabash
Washington
Jefferson
Monroe
Randolph
Perry
Hamilton
White
Franklin
Jackson
Williamson
Saline
Gallatin
Union
Johnson
Pope
Hardin
Alexander
Pulaski
Massac
Quartiles
Q1 (16.3 - 42.1)
Q2 (42.2 - 48.5)
Q3 (48.6 - 57.1)
Q4 (57.2 - 76.3)

Our second summary indicator identified the proportion of families with at least one child under the age of six in each community who had accessed services from more than one service agency or system. The systems tracked in the study included mental health services, substance abuse treatment services, foster care, adult incarceration or juvenile incarceration. Although families were located for purposes of the study within the community in which they lived at the time of the most recent service experience, it is possible that members of these families have lived in other communities over the past 15 years. Also, some of the individuals who have been linked to a specific household may not currently have contact with the child or still live in the household. However, as a summary measure, the indicator is helpful in identifying those communities in which the rate of children under six are living in households in which members are in need of multiple services to address child abuse, substance abuse, mental health issues or criminal behavior is high.

Figures 4-6 presents the distribution of this scale across our sample communities. As with the prior summary indicator, communities were divided into four quartiles based on the range of risk observed within the cluster. Communities that have the darkest shade of red represent those areas in the highest quartile (the top 25%) within their cluster in terms of the rate of young children per 1,000 children 0-5 living in the community who have been linked to a family member who had accessed multiple services or agencies. Among Chicago neighborhoods (Figure 4), the majority of the high risk communities were again located on the city's west and south side, although the specific neighborhoods falling into the highest quartile varied somewhat from the prior indicator. In the townships surrounding the city (Figure 5), it was difficult to assess all townships on this indicator. Overall, 67 of the townships had no multi-system families and three additional townships had fewer than 100 children 0-5. Of those townships in which the population size and number of multi-system families was sufficient to support this analysis, contiguous areas of highest risk were observed in the western and southern portions of Cook County, and central Will County around Joliet. In the balance of the state (Figure 6), areas with the highest concentration of multi-system families were notably less concentrated in specific areas of the state than we observed with our summary risk index. In this case, contiguous counties with a high proportion of multi-system families were observed in the state's most southern region, counties adjacent to St. Louis and other areas of Missouri, and two of the state's most northern counties. Also, two counties in the state's south central area also were identified as having high concentrations of multi-problem families. In considering this pattern, it is important to keep in mind that the absolute number of young children in many of these central and southern counties are relatively low so although the rate of multi-system families may be higher than other counties in this cluster, the actual number of children living in such households may be modest compared to number of children in comparable circumstances in the Chicago metropolitan area.

Figure 4

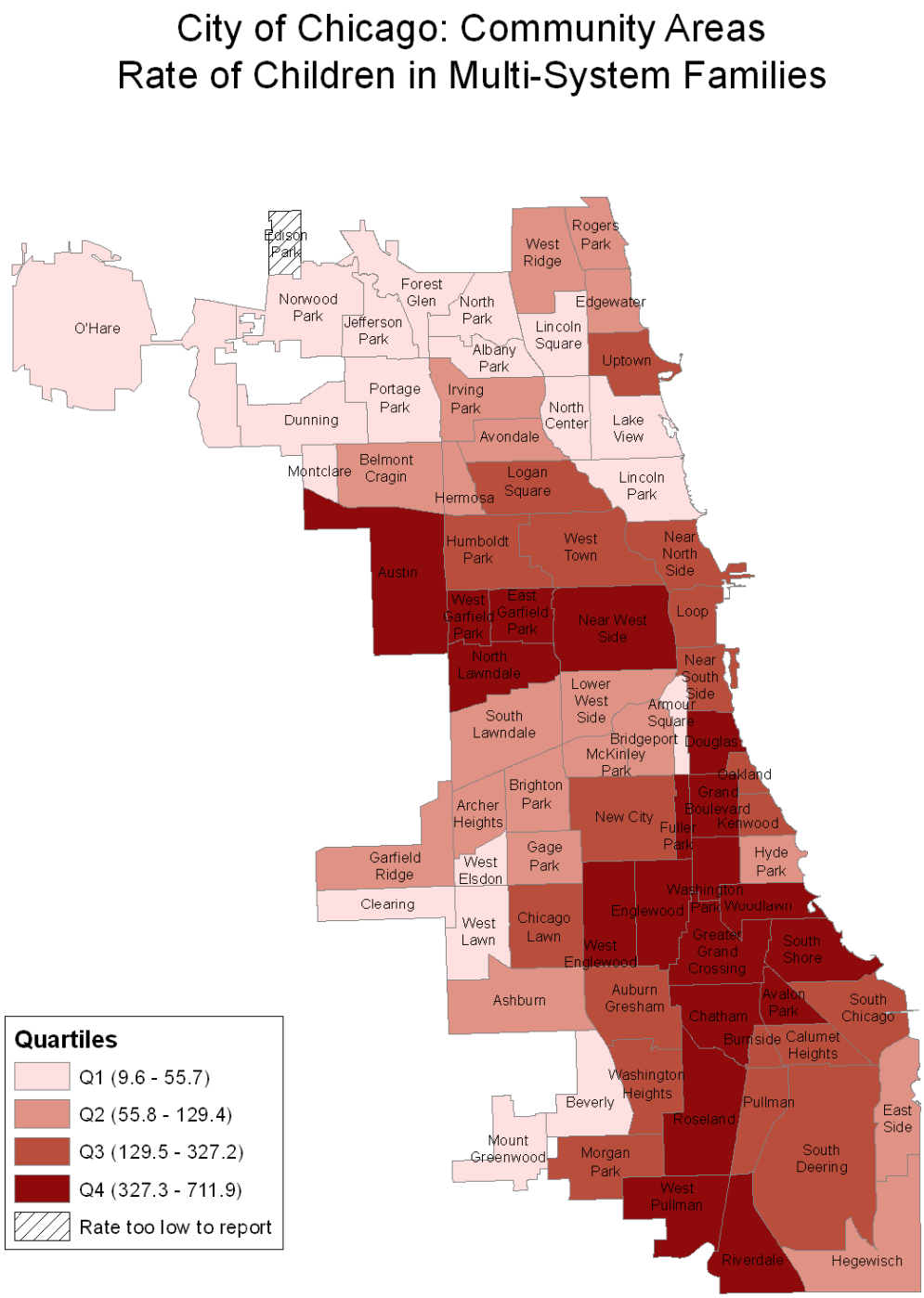

City of Chicago: Community Areas
Rate of Children in Multi-System Families
Edison Park
Rogers Park
West Ridge
Norwood Park
Forest Glen
North Park
Edgewater
O'Hare
Jefferson Park
Lincoln Square
Albany Park
Uptown
Portage Park
Irving Park
Dunning
North Center
Lake View
Avondale
Montclare
Belmont Cragin
Logan Square
Lincoln Park
Hermosa
Humboldt Park
West Town
Near North Side
Austin
West Garfield Park
East Garfield Park
Near West Side
Loop
North Lawndale
Near South Side
Lower West Side
Armour Square
South Lawndale
Bridgeport
Douglas
McKinley Park
Oakland
Brighton Park
Grand Boulevard
Archer Heights
New City
Kenwood
Fuller Park
Garfield Ridge
West Elsdon
Gage Park
Hyde Park
Washington Park
Clearing
Englewood
Woodlawn
West Lawn
Chicago Lawn
Greater Grand Crossing
South Shore
West Englewood
Ashburn
Auburn Gresham
Avalon Park
South Chicago
Chatham
Burnside
Calumet Heights
Washington Heights
Beverly
Pullman
East Side
Roseland
Mount Greenwood
Morgan Park
South Deering
West Pullman
Riverdale
Hegewisch
Quartiles
Q1 (9.6 - 55.7)
Q2 (55.8 - 129.4)
Q3 (129.5 - 327.2)
Q4 (327.3 - 711.9)
Rate too low to report

Figure 5

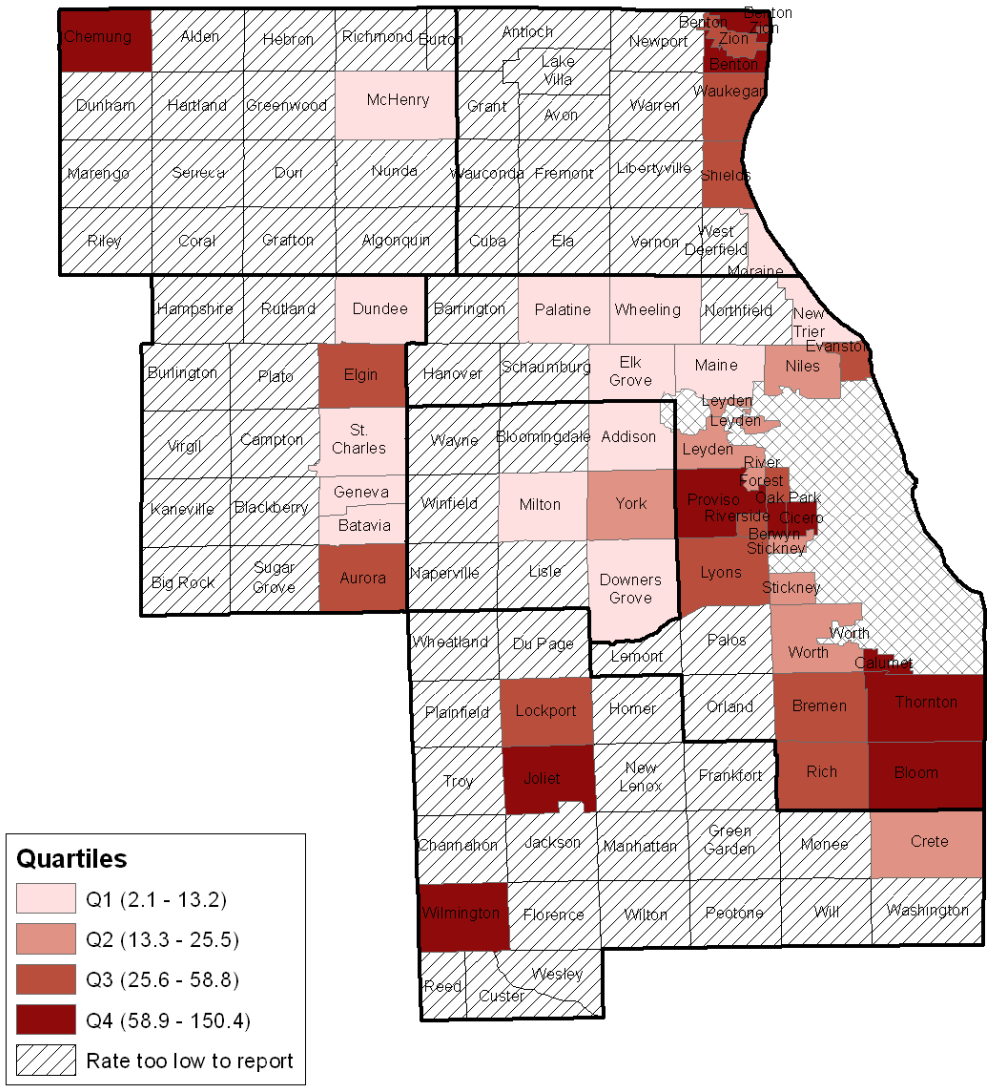
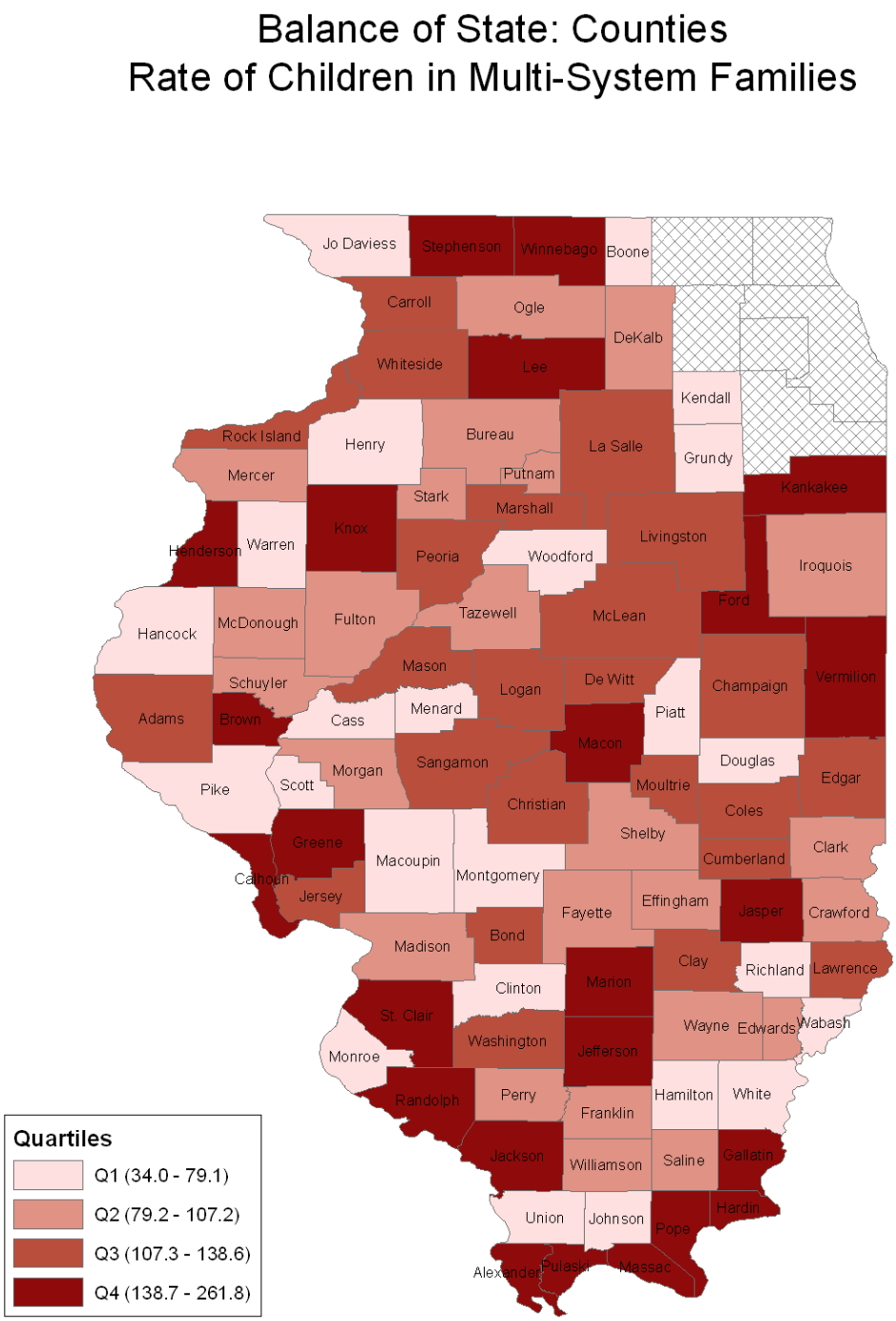

Cook and Collar Counties: Townships
Rate of Children in Multi-System Families
Chemung
Alden
Hebron
Richmond
Burton
Antioch
Lake Villa
Grant
Avon
Newport
Benton
Zion
Waukegan
Warren
Dunham
Hartland
Greenwood
McHenry
Marengo
Seneca
Dorr
Nunda
Wauconda
Fremont
Libertyville
Shields
Riley
Coral
Grafton
Algonquin
Cuba
Ela
Vernon
West Deerfield
Moraine
Hampshire
Rutland
Dundee
Barrington
Palatine
Wheeling
Northfield
New Trier
Evanston
Burlington
Plato
Elgin
Hanover
Schaumburg
Elk Grove
Maine
Niles
Leyden
Virgil
Campton
St. Charles
Wayne
Bloomingdale
Addison
River Forest
Kaneville
Blackberry
Geneva
Batavia
Winfield
Milton
York
Proviso
Oak Park
Riverside
Cicero
Berwyn
Stickney
Big Rock
Sugar Grove
Aurora
Naperville
Lisle
Downers Grove
Lyons
Wheatland
Du Page
Lemont
Palos
Worth
Calumet
Plainfield
Lockport
Homer
Orland
Bremen
Thornton
Troy
Joliet
New Lenox
Frankfort
Rich
Bloom
Channahon
Jackson
Manhattan
Green Garden
Monee
Crete
Wilmington
Florence
Wilton
Peotone
Will
Washington
Reed
Custer
Wesley
Quartiles
Q1 (2.1 - 13.2)
Q2 (13.3 - 25.5)
Q3 (25.6 - 58.8)
Q4 (58.9 - 150.4)
Rate too low to report

Figure 6


Balance of State: Counties
Rate of Children in Multi-System Families
Jo Daviess
Stephenson
Winnebago
Boone
Carroll
Ogle
DeKalb
Whiteside
Lee
Kendall
Rock Island
Henry
Bureau
La Salle
Grundy
Mercer
Putnam
Kankakee
Stark
Marshall
Knox
Livingston
Henderson
Warren
Peoria
Woodford
Iroquois
Hancock
McDonough
Fulton
Tazewell
McLean
Ford
Mason
Vermilion
Schuyler
Logan
De Witt
Champaign
Adams
Brown
Cass
Menard
Piatt
Macon
Douglas
Pike
Morgan
Scott
Sangamon
Moultrie
Edgar
Christian
Coles
Greene
Shelby
Clark
Macoupin
Montgomery
Cumberland
Calhoun
Jersey
Effingham
Jasper
Crawford
Fayette
Madison
Bond
Clay
Richland
Lawrence
Clinton
Marion
St. Clair
Wayne
Edwards
Wabash
Washington
Jefferson
Monroe
Hamilton
White
Randolph
Perry
Franklin
Jackson
Williamson
Saline
Gallatin
Union
Johnson
Pope
Hardin
Alexander
Pulaski
Massac
Quartiles
Q1 (34.0 - 79.1)
Q2 (79.2 - 107.2)
Q3 (107.3 - 138.6)
Q4 (138.7 - 261.8)

In order to further specify those communities at highest risk, we identified the top ten communities on both of these dimensions –high socio-economic risk and poor child outcomes and high rates of children living in households where members were or are engaged in multiple service systems. These communities are identified in Tables 3 (risk index) and 4 (multi-system families). As these tables indicate, 90% of the city neighborhoods identified as being at highest risk on both measures are the same, as are 60% of the townships identified in the communities surrounding Chicago. Regardless of how we measure risk, it appears the communities in the city presenting the greatest challenges for young children and their families are found on the Westside (particularly East and West Garfield Park and Greater Grand Crossing); the Southside (particularly Fuller Park, Washington Park, West Englewood and Englewood); and the far Southside (particularly Riverdale). In the case of the collar townships, the areas of highest risk on both measures include the western and southern portions of Cook County (particularly Cicero, Bloom and Calumet townships); the northeastern portion of Lake County (particularly Benton and Zion townships); the northwest portion of McHenry County (particular Chemung township); and the Joliet area in Will County.

Table 3. Relative Risk as Measured by Summary Risk Index

Chicago: Community Areas		**Cook and Collar Counties: Townships**		**Balance of State: Counties**	
Community	**Score**	**Community**	**Score**	**Community**	**Score**
Fuller Park	81.9	Zion	70.0	Pulaski	76.3
Burnside	79.8	Dunham	68.3	Alexander	75.0
Englewood	75.2	Waukegan	68.2	Vermilion	71.6
West Englewood	72.6	Calumet	65.9	Mason	69.9
West Garfield Park	72.1	Chemung	62.7	Jefferson	66.3
North Lawndale	70.4	Thornton	62.5	White	64.7
Riverdale	69.1	Cicero	61.2	Knox	64.7
Washington Park	68.6	Joliet	59.0	Saline	64.4
East Garfield Park	67.6	Aurora	57.8	Marion	64.3
Greater Grand Crossing	67.5	Bloom	57.3	Macon	63.9

(Rate per 1,000 children 0-5)

Table 4. Relative Concentration of Children 0-5 in Multi-System Families

Chicago: Community Areas		Cook and Collar Counties: Townships		Balance of State: Counties	
Community	**Rate**	**Community**	**Rate**	**Community**	**Rate**
Fuller Park	711.9	Calumet	150.3	Gallatin	261.7
West Garfield Park	611.7	Joliet	149.1	Alexander	255.1
Englewood	599.2	Berwyn	117.3	Pope	229.2
Washington Park	578.2	Thornton	115.9	Pulaski	208.2
Riverdale	556.6	Proviso	93.5	Ford	204.9
East Garfield Park	536.4	Bloom	83.5	Massac	199.0
North Lawndale	526.6	Cicero	82.3	Jasper	193.3
West Englewood	480.9	Wilmington	74.0	Brown	185.8
Greater Grand Crossing	453.9	Benton	68.1	Calhoun	175.8
Austin	405.5	Chemung	67.9	Henderson	167.1

(Rate per 1,000 children 0-5)

Far less consistency was observed across the two measures of relative risk among communities outside the Chicago area. As noted in Tables 3 and 4, only two downstate counties (Alexander and Pulaski) appeared in the top ten counties on both measures. If we consider all of the counties that were ranked in the top quartile on either measure, the number of counties appearing in both groups increases to nine (Alexander, Jefferson, Knox, Macon, Marion, Massac, Pulaski, Vermilion and Winnebago). There are several possible explanations for the differences between the two rankings within this cluster of communities. First, it is possible that defining community as an entire county is too large a geographic area to effectively identify comparable pockets of need. Those families needing assistance in one or more of the dimensions we are examining may be geographically isolated within certain portions of the county. When information on these families is averaged with descriptive information on families living in other parts of the county, the need may become more muted and difficult to detect. Second, the nature of the risk problem and the range of challenges facing families in small towns and rural communities may indeed be vastly different across these communities. The "balance of state" includes some small metropolitan and commercial areas such as Rockford, Peoria, and Springfield as well as very rural communities. Although all three clusters include diverse communities, the level of variation is most notable across the counties. Identifying a single or even multiple risk indicators that work equally well outside the Chicago metropolitan area is challenging, particularly given the scope and quality of the administrative data readily available for this needs assessment.

Because of the variation in context and resources across these three community clusters, it is difficult to directly compare the need for services in certain Chicago communities versus those located downstate. As noted in Tables 3 and 4, the scores for the Chicago neighborhoods were notably higher in many instances that what we observed in the collar townships and, to a lesser extent, in the balance of the state, particularly with respect to the concentration of multi-system families. These data also underscore that

many young children throughout the state are living in families that are characterized by poverty and involvement in multiple services systems including mental health, substance abuse and child welfare. As noted earlier, several downstate counties with high concentrations of risk factors and negative child outcomes have a very low population base, raising questions as to the ability of these communities to provide a sufficient participant base to support one or more of the current evidence based programs being implemented across the state. As such, additional resources may be needed in all three community clusters, but the structure and capacity of these resources are likely different.

General Service Capacity and Implementation

Illinois is currently investing in four national evidence-based home visitation models – Healthy Families Illinois (based on the Healthy Families America program), Nurse Family Partnership, Parents as Teachers, and Early Head Start. In addition to these programs, other home visitation programs targeting young children and their families are operating in the State.[11] For purposes of defining the initial scope and quality of home visitation programs in the State, however, the needs assessment focused on the four models which are most visible in the state and for which statewide capacity could be determined in a reliable manner.

Table 5 summarizes the number of program sites implementing each model as well as the model's service characteristics, general target population, and targeted outcomes. Overall, one or more state agencies have made investments in two Nurse Family Partnership sites, 42 Healthy Families Illinois sites, and 200 Parent as Teachers sites. In addition, there are currently 25 Early Head Start sites operating throughout the state. Collectively, it is estimated that these programs served approximately 20,000 families in FY 2009. Although the number of programs and sites throughout the state exceed what might be found in many other states, current capacity is far short of what would be required to meet the needs of all high risk families. As discussed in the following section, the state's budget crisis and general economic conditions has had major impact on service capacity over the past 12 months. For example, the 140 PAT program sites that were able to provide caseload numbers for both FY 2009 and FY2010 reported a 47% reduction in the number of families they served.

Beyond the question of capacity, the state's current pattern of investment in these programs pose some challenges in providing equal access to these services for all families in need. Figures 7 and 8 show the location of these EBHV programs in both Cook County (which includes the city of Chicago) and the balance of the state and highlight those communities identified as being at highest risk on one or more of

[11] For example, the Parent Child Home Program, a well-researched and supported national program that focuses on early literacy and parent-child interaction, is being provided at two locations in the city with support from the state's early childhood funds.

our summary risk measures. As these figures illustrate, the location of EBHV programs is highly concentrated in the Chicago metropolitan area and that portion of the state across the river from St. Louis, MO. Roughly one-third of the counties have no home visitation program and another third have only one program. In most cases, the single program available in communities outside of Chicago and the greater St. Louis area is PAT, although the relatively small number of EHS and HFI in the state are found in both urban and rural areas.

Figure 7

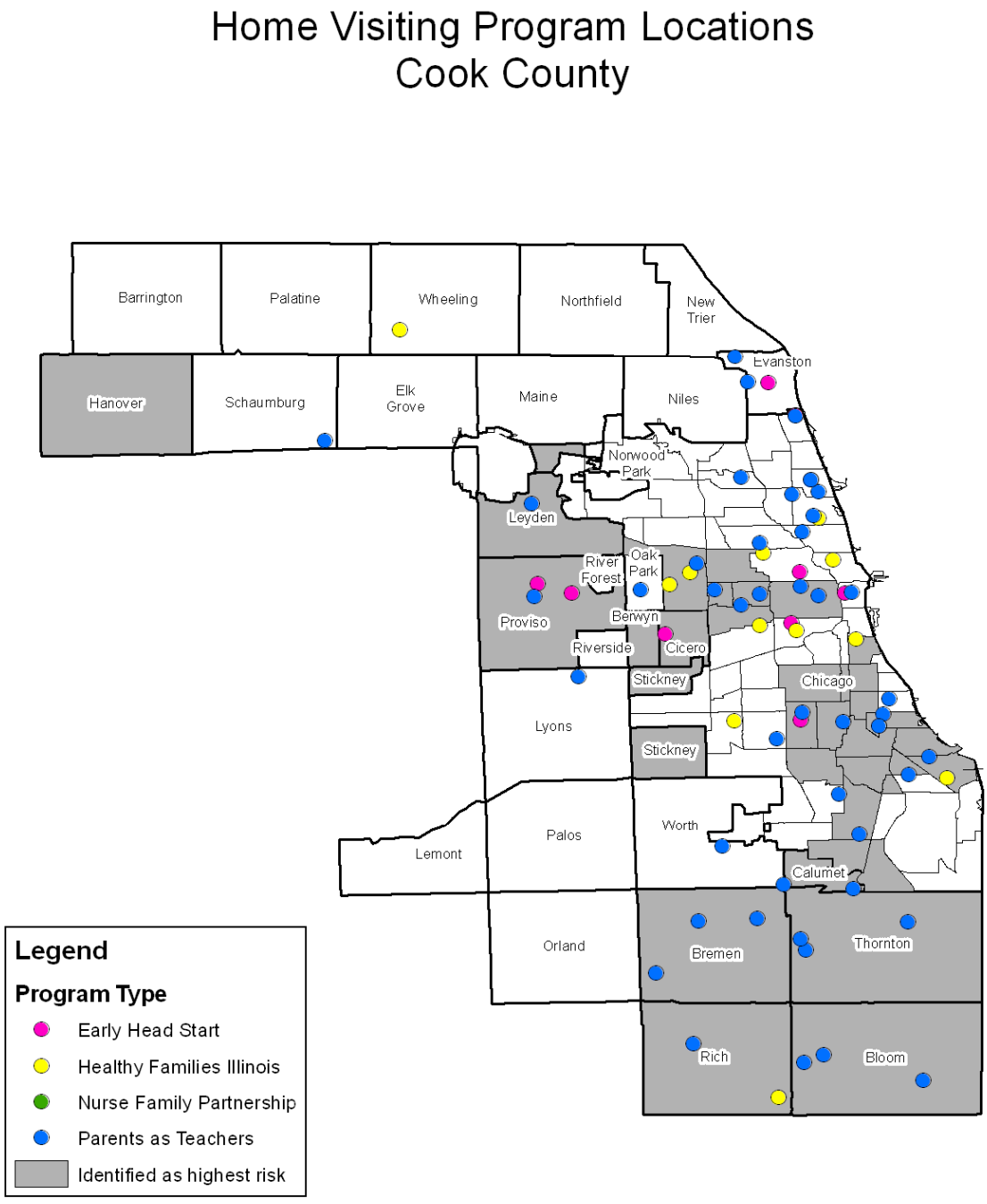
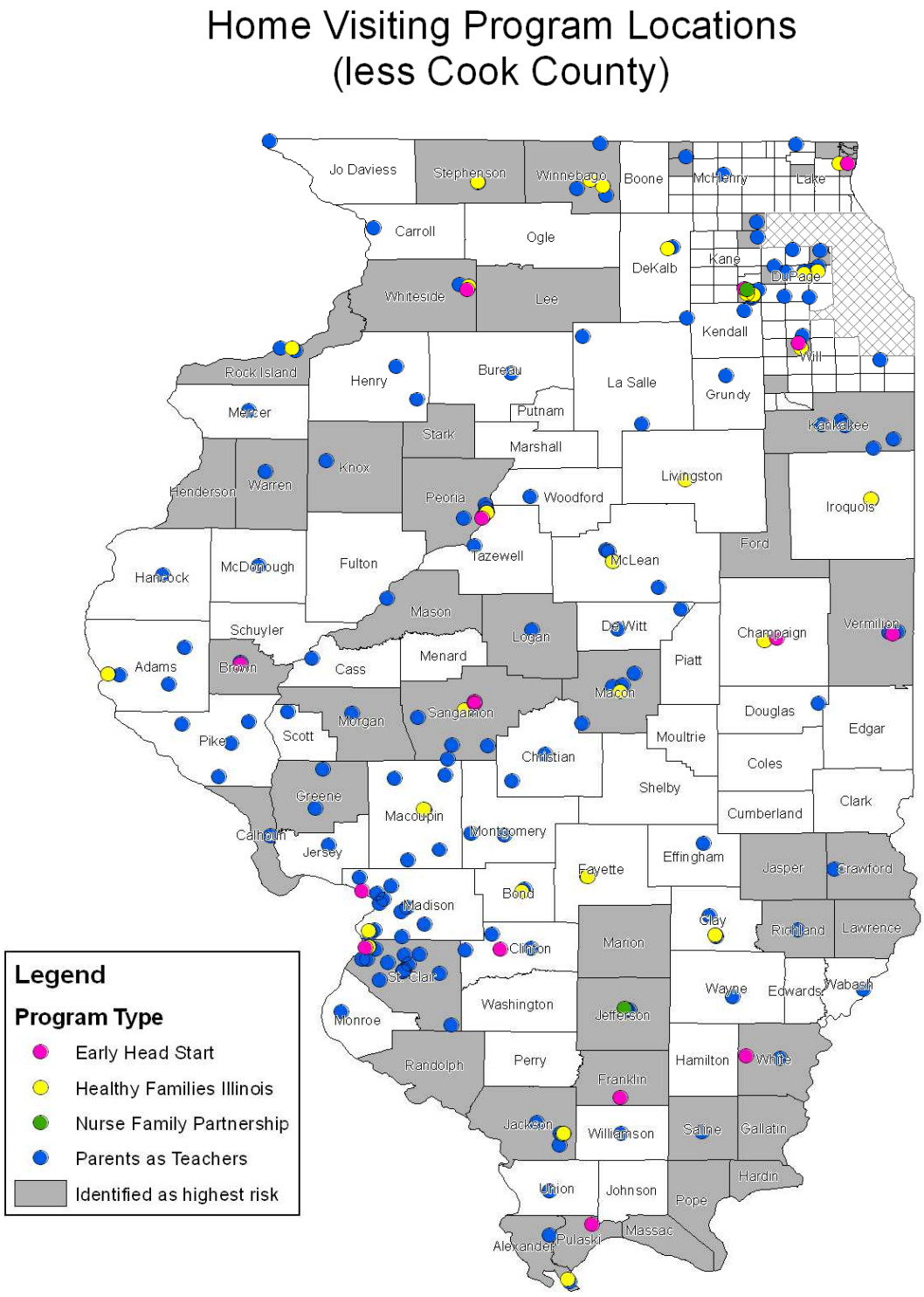

Home Visiting Program Locations
Cook County
Barrington
Palatine
Wheeling
Northfield
New Trier
Evanston
Hanover
Schaumburg
Elk Grove
Maine
Niles
Norwood Park
Leyden
River Forest
Oak Park
Proviso
Berwyn
Riverside
Cicero
Stickney
Chicago
Lyons
Stickney
Worth
Palos
Lemont
Calumet
Orland
Bremen
Thornton
Rich
Bloom
Legend
Program Type
Early Head Start
Healthy Families Illinois
Nurse Family Partnership
Parents as Teachers
Identified as highest risk

Figure 8


Home Visiting Program Locations
(less Cook County)
Jo Daviess
Stephenson
Winnebago
Boone
McHenry
Lake
Carroll
Ogle
DeKalb
Kane
DuPage
Whiteside
Lee
Kendall
Will
Rock Island
Henry
Bureau
La Salle
Grundy
Mercer
Putnam
Kankakee
Stark
Marshall
Knox
Livingston
Henderson
Warren
Peoria
Woodford
Iroquois
Ford
Hancock
McDonough
Fulton
Tazewell
McLean
Mason
Schuyler
Logan
DeWitt
Champaign
Vermilion
Adams
Brown
Cass
Menard
Piatt
Macon
Douglas
Edgar
Morgan
Sangamon
Pike
Scott
Moultrie
Christian
Coles
Shelby
Greene
Clark
Macoupin
Cumberland
Calhoun
Montgomery
Jersey
Effingham
Fayette
Jasper
Crawford
Bond
Madison
Clay
Richland
Lawrence
Marion
Clinton
St. Clair
Wayne
Edwards
Wabash
Washington
Jefferson
Monroe
Randolph
Perry
Hamilton
White
Franklin
Jackson
Williamson
Saline
Gallatin
Union
Johnson
Pope
Hardin
Alexander
Pulaski
Massac
Legend
Program Type
Early Head Start
Healthy Families Illinois
Nurse Family Partnership
Parents as Teachers
Identified as highest risk

Based on the information we have available on all of the EBHV programs, it is difficult to discern the exact scope of each program's catchment area. In most cases, the only consistent "location" information we had for all of the programs was the address of the entity or organization which received the grant or managed the program. This location may or may not fully represent a program's actual service area. For example, the management staff or fiscal agent for PAT programs is often housed within the administrative offices of local districts. Actual services, however, may be extended to families throughout the school district. Similarly, a large non-profit may be the administrator or fiscal agency for an EHS or HFI site but services may be delivered in a location in one or more communities located outside the business office's immediate area. Finally, programs located in communities adjacent to high risk areas might be expected to face "spillover" effects as families living in areas with high concentration of poverty and poor child outcomes seek supportive services for themselves or their children outside their immediate neighborhood. To the extent possible, every effort was made to map the location of a program to its primary service area. In addition, as discussed in the subsequent section, program managers who responded to our survey were asked to provide a general overview of their service area and the average distance home visitors travel to serve program participants. However, this information is not available for all sites. Consequently, our overall assessment may result in an over or under estimate of current capacity in any specific community or area of the state. In developing the final state plan, it will be important to develop more precise estimates of each program's current service area and the extent of unmet demand.

Table 5. Characteristics of State's Intensive Home Based Interventions

Program	# of Program Sites	Target Population	Expected Dosage	Expected Duration	Targeted Outcomes	Estimated # Served 2008-2009
Healthy Families America	42	Pregnant women or new parents within two weeks of birth	Scaled from weekly to quarterly	Until child's 5th birthday	-Promote healthy parent-child interaction and attachment -Increase knowledge of child development and appropriate expectations of children -Improve use of preventive health care -Reduce social isolation -Provide access to community resources	4,767
Nurse Family Partnership	2	First-time pregnant women < 28 weeks gestation	Scaled from weekly to quarterly	Until child's second birthday	-Fewer subsequent reports of CAN -Reduced childhood injury and ingestions -Reduced involvement with juvenile justice -Increase parenting bonding -Increase spacing between pregnancies -Improve cognitive skills in children -Improve health behaviors in pregnant women -Improve child health and development	377

Program	**# of Program Sites**	**Target Population**	**Expected Dosage**	**Expected Duration**	**Targeted Outcomes**	**Estimated # Served 2008-2009**
Parents as Teachers	285	Pregnant women and families with children up to kindergarten entry	Home visits twice a month/monthly group meetings	Until enrollment in kindergarten	-Increase parent knowledge of early childhood development and improve parenting practices -Provide early detection of developmental delays and health issues -Prevent child abuse and neglect -Increase school readiness and school success	12,972[a] 9,415[b]
Home-based Early Head Start	25	Low income pregnant women	Weekly 90 minute home visits plus two group socializations each month.	Pregnancy through child's first three years	-Promote healthy prenatal outcomes for pregnant women -Enhance the development of very young children -Promote healthy family functioning	1,000

[a]This figure is based on data reported by 190 PAT programs to the National PAT office in St. Louis.
[b]This figure is based on data reported by 137 PAT programs participating in an Illinois State Board of Education funded survey conducted by the Erickson Institute in Chicago.

With this caveat in mind, a simple mapping of program locations does suggest a potential shortfall of services in some areas. As noted in Figure 7, a number of different EBHV programs are located in higher risk communities, such as Proviso and Evanston Townships as well as the city's Austin, Garfield Park, and Near West Side communities. More limited EBHV program options appear available in communities on the city's Southside and in southern Cook County. Looking at the distribution of EBHV programs across the balance of the state (Figure 8), it also appears that services have been concentrated in counties or communities that represent the highest risk. Although the high risk communities identified in the collar counties such as Waukegan, Aurora, Joliet have a relatively high concentration of services, fewer service options are available in several downstate communities. This is particularly true in the southern portion of the state.

In the absence of being able to better specify the reach and capacity of each service program, it is difficult to assess the degree to which current levels of investment are adequate or if they are being allocated in the most efficient manner. While it does appear some communities may have a richer array of services than other areas at equal or higher risk, the distribution of services is only partially a function of a community's level of risk as defined by the types of health and well-being measures available for our analysis. It is possible other dimensions of need such as the proportion of undocumented families living in a community or the loss of other critical family support services may justify the expansion of EBHVs option in a given area. Further, communities will differ in their capacity to implement and sustain an EBHV program including the capacity to secure initial and ongoing funding, to hire and retain a qualified work force and to have access to the full range of supportive and therapeutic services program participants may need. Communities that have robust leadership within its school districts, local public agencies and non-profit organizations may find it easier to expand services than communities without this level of leadership. In determining how best to allocate new resources or realign existing resources, it will be important for the State to build on this initial assessment and obtain more comprehensive information on the characteristics of local populations and the capacity of local service systems before committing to expanding programs in any given community.

Substance Abuse Treatment Services

Given the legislative emphasis on substance abuse-related issues, we also explored the general availability of services for pregnant women and new parents presenting with this challenge. Of the 615 substance abuse treatment facilities in Illinois included in the 2009 National Survey of Substance Abuse Treatment Services, only 45 (or 7.3%) report having programs that target pregnant or postpartum women. Only 14 of these facilities (or 2.3% of all facilities) provide resident beds for the children of these women. As with home visitation services, the majority of substance abuse treatment facilities specializing in pregnant and

post-partum women are located in Chicago. Unlike home visitation programs, however, enrollees in in-patient programs at facilities such as Haymarket and the Women's Treatment Center come from all over the state. During their stay in these and similar residential treatment centers, women have access to a range of medical and other supportive services, the majority of which are provided on site. These services include access to a medical clinic, mental health services, child care, parenting education classes, job training and educational assistance, and supportive service for other family members. Women also can access these services on an out-patient basis during pregnancy and after termination from the in-patient services. Indeed one of the strengths of these programs is the broad array of supportive and basic care services a woman can access while in residential treatment or as an out-patient. Those working in these facilities underscored the importance of having in-house capacity to provide a broad range of ancillary services, adding that expecting women who are struggling with addiction to manage complex service delivery systems on their own is unrealistic.

Beyond these small number of high-quality intensive therapeutic programs, few options exist for pregnant women and new parents experiencing substance abuse problems. This would suggest that enhanced services for pregnant women and new parents are needed throughout the state. Areas in which capacity building might be needed include: placement of assessment counselors within existing EBHV models to facilitate the appropriate identification of substance abuse issues among those accessing these models and to develop collaborative relationships with those agencies that serve women and young children; the expansion of in-patient services for women identified with this problem within the current network of substance abuse treatment programs; and the expansion of follow-up services for women who graduate from these programs in order to facilitate the provision of appropriate aftercare services for their young children.

Home Visitation Service Capacity

In order to obtain a more nuanced understanding of the capacity and quality of the EBHV programs currently being provided in the state, we solicited input from the managers of these home visitation programs. Specifically managers were asked to comment on the primary characteristics and needs of the families they are enrolling; the ability to meet current demand as evidenced by the development and size of a wait-list for referrals; size and shifts in caseload capacity; the degree to which their staff have access to key ancillary services needed to fully address the needs of their participants; and the impacts state budget cuts and other economic issues are having on their operations. Each of these issues is discussed below. In order to assess how these responses might have varied across programs located in different areas of the state, responses have been aggregated by program service area (i.e., programs serving families in Chicago; programs serving families in the suburban communities surrounding Chicago; and

those located in the balance of the state). Our response rate for all programs within each community cluster were comparable, with 53% of Chicago programs responding, 42% of the collar county programs responding, and 45% of the programs located in the balance of the state responding.

Caseload Characteristics

Table 6 summarizes the program managers' estimates of the proportion of participants enrolled in their programs with specific characteristics or presenting problems. As this table illustrates, program managers report enrolling families that represent significant risk, particularly in terms of the proportion of low income families and single parent households being served. On average, almost 96% of the families served by home visitation programs in the city are low income as are over 80% of the families served by programs operating in the collar counties or in the balance of the state. While over three-quarters of the families enrolling in city programs are single parents, 62% of parents served by programs operating in the balance of the state are single parents at the time they enroll in the program as are almost 50% of the families served by programs in the collar counties. Although the average caseloads of the Chicago programs generally include a higher proportion of families with a number of risk factors (teen parents, those lacking a high school education, homeless families, and those unemployed), families with these characteristics also are being seen by programs operating in other areas of the state. In addition, programs serving suburban communities report that their caseloads include, on average, a greater proportion of non-English speaking participants, undocumented immigrants, families dealing with social isolation, and parents presenting with clinical depression and other mental health issues than programs operating in the city. Program serving families in the balance of the state report the highest concentrations of families addressing active substance abuse issues, infants requiring early intervention (Part C) services, parents with a developmental delay and families struggling with a serious mental health issue, although the percentage of such cases are relatively small. In considering these variations, it is important to remember that these distributions reflect judgments on the part of the program managers. As such, the proportions in Table 6 represent the extent to which program managers observe specific characteristics among their participants or have had occasion to refer families for different presenting problems. The actual proportion of families enrolled in home visitation services that present with these characteristics or are in need of specific services may vary from these estimates.

Table 6. Participant Characteristics by Community Cluster

Characteristic	Program Location		
	Chicago	Cook (less Chicago) and Collar Counties	Balance of State
Non-English speaking	21.1%	37.2%	5.1%
Undocumented immigrants	24.8%	31.9%	3.4%
Teen parents (under 20 years of age)	71.6%	36.1%	30.5%
Single parent	78.0%	49.3%	61.5%
Low income (e.g., WIC eligible)	95.8%	82.6%	86.0%
Lacking a high school diploma/GED	47.5%	45.0%	34.0%
Homeless or unstable housing	20.0%	16.2%	17.4%
Unemployed and seeking work	54.6%	38.1%	46.7%
Socially isolated	25.2%	37.5%	29.6%
Lacking auto/transportation resources	44.6%	37.6%	38.2%
Active substance abuse issue	6.1%	7.7%	12.6%
Clinical depression/mental health issues	17.3%	28.1%	20.8%
Domestic violence issues	16.2%	15.0%	16.1%
Infant enrolled in early intervention (Part C)	4.9%	8.1%	12.4%
Parent with developmental delay	3.2%	6.4%	10.2%
Serious physical health issue	2.7%	6.4%	6.6%
N	22	20	68

Percentage of caseloads demonstrating risk factors.

These findings further support the state's growing diversity due to the migration of ethnic populations beyond the city boundaries and the pervasive economic problems impacting all families. The findings also suggest that the current pool of EBHV programs are focusing primarily on families that face socio-economic risks related to young maternal age and single parent status. Relatively few families who are identified with serious substance abuse, mental health or domestic violence issues are enrolling in EBHV programs. For example, program managers estimate that between 17 to 28% of their caseloads, on average, present with clinical depression or other mental health concerns; approximately 15% of their caseloads struggle with issues of domestic violence; and 6 to 12% of their families have an active substance abuse problem. Even fewer parents who require developmental services for themselves or their children are engaging in these services. It is possible that the proportion of program caseloads presenting with these problems is reflective of the actual frequency of these problems among the new parent population. It also is possible, however, that the current pool of EBHV programs are not well suited to identify and therefore address these concerns or that new parents struggling with such issues are not inclined to seek out or enroll in voluntary home based services.

Wait-List Issues

Of the programs we contacted, over 80% maintain a wait-list to accommodate referrals to the program when the program is operating at full capacity, although relatively few families were currently on these

lists awaiting services. At the time we conducted the survey, a total of 74 families were on the wait-lists at 30 programs.[12] The majority of the programs with active wait-lists were located outside Chicago and its collar counties. While on a wait-list, a family may be offered a range of assistance including playgroups, informational material on parenting, referrals to other services, or developmental screenings.

Service Capacity and Caseloads

Program managers responding to the survey reported a total service capacity of 9,315 families. Of these program "slots", 21% are in programs serving families in Chicago, 18% are in programs serving families in the townships surrounding the city, and 61% are in programs serving families in the balance of the State. Because we did not obtain caseload information on all of the EBHV programs in the State, these numbers do not represent the total number of home visitation slots available in each of these community clusters and offer only an estimate of the distribution of slots across State regions.

At present, the programs represented in the survey appear to be operating at around 72% of their actual capacity. Overall, program managers responding to the survey reported that they currently enroll 6,735 families. Looking across the three clusters, 81% of the program slots in Chicago, 78% of the program slots in the collar townships, and 68% of the program slots downstate are currently filled. As noted earlier, this pattern may reflect the overall decline in program enrollment often observed during the summer months and the fact that some EBHV programs, such as PAT, do not always operate year round. Also, it is possible families may be more reluctant at the moment to enroll in these programs in light of the State's overall budget picture. Unless a potential participant is convinced that a program will be operating for the next year, she may not be willing to make the commitment required to fully engage in these types of relationship based interventions.

For those programs able to provide us with the total number of families served in both FY 09 and FY 10, we found service levels to be relatively stable. Among the programs operating in the city, the numbers of families served both years were virtually identical (1,932 in FY 10 versus 1,937 in FY 09). Similarly, programs operating in the balance of the State served about 1% fewer families in the most recent reporting period (6,390 in FY 10 versus 6,455 in FY 09). In contrast, programs operating in the collar townships saw a 10% drop in the number of families they served (1,458 in FY 10 versus 1,607 in FY 09). Again, these trends are based on only a sample of EBHV programs and may not reflect actual changes in

[12] The relatively low number of families on the wait-lists of these EBHV programs may in part reflect the timing of our data collection. Program enrollment and demand often declines in the summer. In contrast to our pattern, the recent survey of PAT program sites conducted by the Erikson Institute reported 1,012 families on the wait-lists maintained by 55 programs as of November 9, 2009.

service capacity across the three community clusters. It is possible that those programs responding to the survey represent a more robust group of organizations and therefore a group more likely to sustain program capacity even under difficult fiscal circumstances.

Capacity to Provide Ancillary Services

For evidence-based home visitation programs to achieve maximum impacts, home visitors must have access to a range of community services such as primary health care, mental health services, other therapeutic interventions and programs offering an array of basic needs. When such services not readily available or of sufficient quality, robust participant impacts in many domains may be threatened. As summarized in Table 7, home visitors frequently draw on other local services to meet the diverse needs of their program participants. For each service domain, managers were asked if their home visitors make these types of referrals often (3 points), occasionally (2 points), or rarely (1 point). On this 3-point scale, services that were identified as being the most common referrals home visitors make include basic infant and household items (2.6 to 2.8); child care (2.5 to 2.6); employment counseling or job assistance (2.4); primary health care (2.3 to 2.6); and income maintenance services (2.3). Notably fewer referrals are being made for domestic violence counseling or shelter (1.9 to 2.0); homelessness (1.6 to 2.0); infant and early childhood mental health (1.7 to 1.9); substance abuse treatment (1.4 to 1.5); and services for parental developmental delays (1.4 to 1.5), perhaps reflecting the relatively few number of cases presenting with these problems as noted above. For those service domains in which there was variation in the frequency of referrals across the three community clusters, programs operating in Chicago were most likely to make referrals for domestic violence and homelessness while programs serving families in the collar counties were most likely to refer families to primary health care resources, adult mental health services and access to basic infant and household items. Programs serving families operating in the balance of the state were most likely to make referrals for infant and early childhood mental health and assistance with child developmental delays. These variations may reflect differences in the characteristics and needs of the families these programs serve as well as differences in the actual availability of these types of service resources.

Table 7. Service Referrals: Relative Frequency by Community Cluster

Service Category	Program Location		
	Chicago	Cook (less Chicago) and Collar Counties	Balance of State
Primary health care	2.4	2.7	2.3
Mental health services for parent	1.9	2.4	2.1
Substance abuse treatment for parent	1.3	1.6	1.6
Domestic violence counseling or shelter	2.0	1.9	1.9
Services for parental developmental delays	1.5	1.4	1.5
Homelessness	2.0	1.7	1.9
Basic infant and household items	2.6	2.8	2.7
Infant and early childhood mental health	1.7	1.7	1.9
Assistance with child developmental delays	2.0	2.0	2.3
Income maintenance services	2.3	2.3	2.3
Employment counseling/job assistance	2.5	2.4	2.4
Child care	2.6	2.7	2.5
N	22	20	68

Program managers were asked to indicate the frequency with which home visitors provided referrals in each area. Numerical values were assigned these rating as follows -- 3 points for often; 2 points for occasionally; and 1 point for rarely. The values in each cell reflect the average scores across all programs operating within each community cluster.

Another potential barrier to the effective use of service referrals as a strategy to extend and strengthen the outcomes of EBHV programs is the quality of local service networks. When program managers were asked to rate the relative quality of different service domains on a three point scale with 3 being very good, 2 being adequate, and 1 being poor, only two service domains were rated as being above adequate across all three community clusters. As summarized in Table 8, average ratings for primary health care services and assistance with child developmental delays were the only two service areas in which program managers from all three community clusters rated services as above the "adequate" level. In addition, program managers operating in the city also rated local child care services as being more than adequate in terms of quality. In all other areas, average rating provided by the program managers were less than 2, suggesting that current service quality in these areas are less than adequate and, in certain instances, poor. On balance, average ratings within each cluster were remarkably similar across all service domains. In addition to the higher average rating of child care services observed among programs managers operating in the city, program managers operating in the collar counties offered more positive assessments of local primary health care services and income maintenance services then providers operating in other areas of the state. Providers operating outside the Chicago metropolitan area provided a more positive assessment of local services to assist children with developmental delays and more negative assessments of services to address homelessness than providers working in the greater Chicago metropolitan area.

Looking forward, many of the program managers anticipate that the availability of these services may become more limited, as state budget reductions continue and other trends in the economy impact the full spectrum of local service providers. Almost half (47%) of the program managers responding to the survey anticipate seeing decreases in the availability of adult mental health services and substance abuse treatment services in their communities. Over one-third anticipate reductions in services addressing the issues of domestic violence services, children's mental health, income maintenance, and homelessness. Respondents were more optimistic about the future availability of others services and anticipate increases in services involving primary health, employment counseling, and addressing developmental delays.

Table 8. Service Referrals: Relative Quality by Community Cluster

Service Category	Program Location		
	Chicago	Cook (less Chicago) and Collar Counties	Balance of State
Primary health care	2.1	2.3	2.0
Mental health services for parent	1.6	1.5	1.6
Substance abuse treatment for parent	1.8	1.6	1.7
Domestic violence counseling or shelter	1.9	1.8	1.9
Services for parental developmental delays	1.7	1.8	1.7
Homelessness	1.5	1.5	1.3
Basic infant and household items	1.8	1.9	1.8
Infant and early childhood mental health	1.7	1.5	1.6
Assistance with child developmental delays	2.1	2.1	2.3
Income maintenance services	1.3	1.8	1.5
Employment counseling/job assistance	1.6	1.6	1.7
Child care	2.1	1.8	1.8
N	22	20	68

Program managers were asked to indicate the overall quality of the services available in each service domain. Numerical values were assigned these rating as follows -- 3 points for very good; 2 points for adequate; and 1 point for poor. The values in each cell reflect the average scores across all programs operating within each community cluster.

Budget Impacts

Table 9 summarizes the degree to which state budget cuts and delays in payments have impacted the operation of home visitation programs. Overall, only 15% of program managers responding to the survey indicated that recent state budget cuts and funding uncertainty has had no impact on their operations. Program providers operating in the collar counties were slightly more likely than providers working in other areas of the State to share this perspective. In contrast to this observation, most program providers reported that current fiscal conditions were having moderate to severe impacts on their operations. Again, providers in the collar counties were more likely to report moderate impacts while those operating in the city and outside the Chicago metropolitan areas reported more substantial impacts. For those programs that reported moderate to substantial impacts, the most common outcomes of these fiscal limitations include the following:

- 51% of programs laid off a total of 122 staff in the past year;
- 32% of programs reduced staff hours;
- 21% of programs increased caseloads, reduced service intensity or dosage, or eliminated other supports for participants; and
- 47% of programs reduced or eliminated professional development opportunities.

Not only does each of these issues impact capacity, they also have implications for quality, as noted in the following section.

Service Quality Issues

In addition to having a sufficient number of service opportunities for high risk families, it is equally important that those services that are available reflect high quality. Although the identification of service quality is a complex and ongoing process, our survey of program managers allowed us to examine some preliminary quality indicators. Specifically, we examined the extent to which the current pool of evidence-based home visitation programs have been credentialed or certified by the relevant national models; the program's success in enrolling a high proportion of its referrals and providing at least half or more of planned home visits; the qualifications of their home visitors, including the program's bilingual capacity; the supervisory strategies and training options offered staff; and the program's involvement in local partnerships and collaborations. Each of these issues is discussed below.

Credential/certification status

An initial indicator of quality or fidelity to a program model is the extent to which an implementing agency embrace all of a model's practice standards and operational guidelines. All of the EBHV models operating in the state require that those seeking to implement their model demonstrate the capacity to follow guidelines and, most cases, secure training for their home visitor and supervisors around practice principals and program content. In addition, all of the models have a certification or credentialing process that holds programs accountable to these standards over time. In some cases, such as HFI, this process involves periodic self-assessments and peer reviews to determine the extent to which an implementing agency is conforming to the model's critical elements governing such issues as participant identification and engagement, service delivery, staff qualifications and service integration. In other cases, such as NFP, implementing agencies provide the national office participant level data on an ongoing basis which document the characteristics of program participants and their service experiences.

Table 9. Estimated Impact of State Budget Cuts

State Budget Impacts	Program Location		
	Chicago	Cook (less Chicago) and Collar Counties	Balance of State
No Impact	14.3%	21.1%	13.2%
Moderate Impact	33.3%	57.9%	41.2%
Substantial Impact	52.4%	21.1%	45.6%
N	22	20	68

Of the programs participating in the survey, 74% have been reviewed by the relevant national model and found to be in compliance with model guidelines. Looking across the four models we examined, 56% of the HFI sites hold a Healthy Families America Credential; 48% of the providers delivering PAT have completed the PAT self-assessment (the first step towards PAT Commendation); both of the local NFP sites have had their program's operational plan approved by the NFP National Service Office; and 88% of the responding EHS sites have completed a Federal Review with no deficiencies. While we cannot be certain that those programs not responding to the survey have achieved similar compliance with national model specifications, it would appear the majority of state providers are operating in a manner consistent with national model expectations.

Enrollment and retention levels

On balance, the vast majority of families referred to these programs accept enrollment. Less than 5% of the program directors we surveyed indicated that more than a quarter of their referrals refuse enrollment. Indeed over 70% of respondents reported that less than 10% of those referred for these intensive home visitation services refuse this assistance. Although most families are initially accepting of these services, it can be challenging to retain participants and successfully complete the number of home visits the models recommend as being central to achieving participant impacts. Of those program managers responding to the survey, the average home visit completion rate (i.e., the number of completed home visits divided by the number of expected home visits) was 72.5, with a range of 1 to 100. For those respondents unable to provide this estimate, most reported that the majority of their families do receive at least 50% of the visits that are attempted.

Staff qualifications

Table 10 summarizes the basic characteristics of the home visitors and supervisors employed by home visitation programs operating in different areas of the state. As this table highlights, the majority of home visitors working in this sample of EBHV programs (70%) have bachelor or masters degrees. This proportion of degreed versus non-degreed staff varies across the three community clusters, with programs operating in the city more likely to hire non-degreed persons and programs operating in the collar

counties less likely to hire home visitors that do not have a college degree. In terms of race, the home visitors employed in city programs are notable less likely to be white and more likely to be African American. The proportion of Hispanic workers in comparable in both the city and collar township programs, reflecting in part the high proportion of non-English speaking and undocumented immigrants that live in these suburban communities. Of the three community clusters, the least racial diversity was observed among the home visitors working in the balance of the State, where over three-quarters of the home visitors are White. In terms of bilingual capacity, almost 90% of the EBHV programs operating in the collar townships and 64% of city programs employ one or more home visitors that are bilingual. Less than one-quarter of the programs operating in the balance of the State have this particular staff capacity.

These data suggest that the EBHV programs in the State are staffed by home visitors with multiple years of experience delivering home visiting services and tenure in their current job. Across all three community cultures, the current pool of home visitors have 5.5 to 6 years of experience providing home based interventions and 4 to 5 years invested in their current position. Although these levels are impressive, it is important to note that this does not mean that staff turnover is not a potential challenges for this group of home based services. As noted in an earlier section, the current fiscal difficulties in the State have required programs to reduce their workforce and programs may have terminated workers with the least experience or job tenure. Also, there was wide variation in the level of experience and job tenure reported by this group of home visitors. While the average or mean rating on these two dimensions is high, most programs also have staff relatively new to the job and with far less experience.

Table 10. Home Visitor Staff Characteristics by Community Cluster

Staff Characteristics	Program Location		
	Chicago	Cook (less Chicago) and Collar Counties	Balance of State
Educational Level			
Masters degree or greater	17.1%	22.7%	13.1%
BA level	42.1%	56.7%	56.3%
Less than BA level	40.7%	20.6%	30.7%
Race			
White	7.9%	44.8%	77.1%
Black	50.7%	18.8%	17.6%
Hispanic	37.9%	35.4%	4.8%
Other	3.6%	1.0%	0.6%
Experience in home visitation			
Mean number of months	72	67	71
Range	1-276	0-240	0-324
Months in current job			
Mean number of months	52	49	59
Range	1-276	0-195	0-324
Bilingual Capacity			
Number of bilingual staff	64	45	19
% of programs in area with at least one bilingual staff members	63.6%	89.5%	22.4%
N	141	98	337

Supervisory strategies

Table 11 reports the frequency of various supervisory strategies employed by home visiting programs operating in various areas of the State. Remarkable consistency exists across programs operating in all three community clusters in the level and types of supervision provided home visitors. The most consistent form of supervision programs provide home visitors is individual meetings in which the supervisor and home visitor discuss the worker's current caseload and develop appropriate strategies for addressing emerging problems or challenges. On average, these types of meetings are held weekly or, at a minimum, three to four times a month. Program managers also report holding group supervisory sessions with their staff, although these occur less frequently (between monthly and two to three times a month) and are not offered in all programs. Programs operating outside the Chicago metropolitan area were less likely to hold group supervisory sessions than programs operating in the city or collar townships. Finally, most supervisors in all three community clusters also conduct in-home observations of the home visitors, although such sessions occur, on average, monthly.

Table 11. Supervisory Strategies

Strategies	Program Location		
	Chicago	Cook (less Chicago) and Collar Counties	Balance of State
Individual meetings w/staff			
% programs using strategy	100.0%	95.0%	94.1%
Relative Frequency	3.8	3.2	3.2
Group supervision			
% programs using strategy	100.0%	95.0%	88.2%
Relative Frequency	3.0	2.6	2.5
Direct Observations in home			
% programs using strategy	90.9%	90.0%	88.2%
Relative Frequency	1.3	1.3	1.1
N	22	20	68

Program managers were asked to report the frequency with which each strategy is provided. Numerical values were assigned these rating as follows -- 4 points for weekly; 3 points for two to three times a month; 2 points for monthly; and 1 point for less than monthly. The values in each cell reflect the average scores across all programs operating within each community cluster.

Training opportunities

Equally important for insuring home visitor quality is the training staff initially receive and the opportunities provided for ongoing professional development. A wide range of basic and enhanced training opportunities were provided EBHV programs by the Ounce of Prevention Fund's Training Institute from July 2009 through June 2010. Drawing on information provided by the Ounce, we examined the number of training sessions each of the 148 EBHV programs for which we had contact information attended during this period. On average, these 148 programs sent their staff to 5.8 trainings during the most recent fiscal year. As might be expected, EBHV program staff located in Chicago were more likely to access these trainings than were staff working elsewhere in the State. The 31 programs operating in the city sent their staff to an average of 9.7 training events last year (with a range of 1 to 36); programs operating in the collar townships sent their staff to an average of 6.5 training events last year (with a range of 1 to 25); and programs operating in outside the metropolitan area sent their staff to an average of 4.1 training events last year (with a range of 1 to 23). As noted on the table, about one-third of these trainings represented the core training staff are required to receive in order to deliver specific models, such as HFI or PAT. The balance of the trainings addresses a wide range of issues, many of which were associated with improving service quality and staff skills in addressing specific populations or participant needs. This high number of trainings provided each programs and the diversity of topics covered suggest that this group of EBHV programs are actively engaged in continuous program improvement.

In addition to the trainings offered by the Ounce, the majority of programs provided additional training options for their direct service personnel. As summarized in Table 12, approximately three-quarters of all

program managers responding to the survey reported offering their staff on-site training opportunities, with programs operating in the collar counties offering this option more frequently (10.1 sessions on average) than program operating in the city (7.1 sessions on average) or those programs operating in the balance of the State (7.5 sessions on average). Virtually all of the programs offered staff the opportunity for off-site training, again with greatest number of opportunities provided to staff working in the collar townships. Distance training options were least common method of offering training to staff across all three community clusters, although the method was most frequently used by programs operating outside the Chicago area.

Table 12. Program Initiated Training

Training Opportunities	**Program Location**		
	Chicago	**Cook (less Chicago) and Collar Counties**	**Balance of State**
On-site training opportunities			
Percent of programs	86.4%	85.0%	75.0%
Mean	7.1	10.1	7.5
Off-site training opportunities			
Percent of programs	90.9%	90.0%	85.3%
Mean	4.2	7.6	5.4
Training via webinar or teleconference			
Percent of programs	68.2%	70.0%	60.3%
Mean	1.6	2.7	3.4
N	22	20	68

Involvement in partnerships and collaborations

The majority of the program managers we surveyed indicated that they are involved one or more local collaboratives around the issue of early intervention and support for new parents. Programs operating in all areas of the state are engaged with other local service providers, community residents and public agencies in building a stronger response for new parents. The most common collaboratives cited by respondents included: All Our Kids (AOK) Network, Child and Family Connections, Local Interagency Councils (LIC), and Strengthening Families.

Table 13 indicates the degree to which programs across the State have participated in or played a lead role in various activities undertaken by these and other local collaboratives. Over two-thirds of programs managers operating in the collar counties and outside the Chicago metropolitan area and 57% of the program managers operating in Chicago reported engaging with other local partners around the issue of service collaboration. Other common activities for local collaboratives included the development of shared training opportunities (reported by roughly 60% of the respondents); legislative advocacy

(reported by about half of the respondents); and public education and awareness (also reported by about half of the respondents). Overall, programs managers operating in the collar counties were more likely to report participating in a wider range of collaborative activities than program managers in either the city or outside the metropolitan area. The two exceptions to this pattern was a slightly higher frequency among program managers operating outside the metropolitan area in collaborative activities around shared training opportunities and public engagement and awareness. Program managers in all three community clusters were less likely to report engaging in collaborative efforts to expand funding opportunities or funding levels or to develop joint program evaluation or assessment efforts.

Table 13. Participation and Leadership in Local Collaborations

Activity	**Program Location**					
	Chicago		**Cook (less Chicago) and Collar Counties**		**Balance of State**	
	Participate	**Lead**	**Participate**	**Lead**	**Participate**	**Lead**
Improve service collaboration	54.5%	18.2%	65.0%	55.0%	67.6%	36.8%
Develop shared training	59.1%	27.3%	55.0%	35.0%	61.8%	29.4%
Joint program evaluation or assessment	40.9%	9.1%	45.0%	15.0%	35.3%	14.7%
Expanding funding opportunities/funding levels	36.4%	4.5%	40.0%	25.0%	38.2%	11.8%
Legislative advocacy	54.5%	13.6%	50.0%	30.0%	51.5%	22.1%
Shared space/facilities	45.5%	18.2%	55.0%	25.0%	48.5%	25.0%
Public education and awareness	50.0%	13.6%	45.0%	25.0%	54.4%	22.1%
N	22		20		68	

Notable differences were observed in the extent to which program managers operating in the three community clusters assumed a leadership role in these collaboratives. On balance, program managers in the collar counties were significantly more likely to report taking a leadership role in all of the activity areas we examined than were program managers operating elsewhere in the State. This difference was greatest between providers operating in the collar townships and those operating in the city. It is possible that this difference reflects the fact that Chicago has a number of statewide advocacy organizations that provide leadership and direction to local coalitions operating in the city, allowing local home visitation program managers to assume a more supportive role. Also, to the extent EBHV programs are housed within larger non-profit organizations in the city, leadership in local coalitions may be assumed by the directors or other management personnel within these organizations rather than by direct service staff. In other areas of the state, leadership responsibility for local collaboratives may be more heavily vested in smaller, direct service organization providing local EBHV managers more opportunities to assume these roles. Regardless of local conditions, it does appear that EBHV program managers are heavily engaged in their local service system and working collaboratively to improve practice.

Conclusions

The needs assessment process and findings offer the State a strong foundation on which to build a more coordinated and comprehensive approach to providing appropriate support to pregnant women and new parents. Further, the process confirmed and, in many instances, enhanced the recommendations and findings that have emerged in other statewide needs assessments, including those conducted as part of the Title V MCH Block Grant Program, the CAPTA inventory of unmet needs, and the Head Start strategic planning process. The purpose of this section is to summarize our findings with respect to the identification of high risk communities, to outline specific challenges that may impact the scope and content of the State's final plan for directing future EBHV investments, and to provide some initial insights regarding next steps.

Data Limitations

The data used to complete the needs assessment has several limitations. First, the limited time frame provided to conduct the needs assessment required us to draw extensively on administrative data sources for summarizing the distribution of risk factors and adverse child outcomes. These data come from multiple sources and cover different time periods. Such data are most useful in computing rates of given events in high density areas; estimates generated from these data are less reliable when a community has a low population base. For purposes of this study, this limitation primarily impacts our estimates of the scope of various problems in the smaller, downstate counties. Also, the quality of these data will vary across communities and administrative agencies. Although these data are often used to measure the scope of many social problems, they are not perfect measures and may well leave certain populations undercounted. Second, our assessment of program and service quality is limited to the information we could obtain through the program manager survey. This instrument allowed us to assess several key structural elements regarding service fidelity such as model certification, staff qualifications, training and supervision, the rate of completed home visits, and involvement in statewide and local collaborative partnerships. However, we were not able to observe the delivery of services or obtain external assessments of how participants and others in the community perceive these programs. In terms of assessing the quality of other services in these communities, we had to rely on the perceptions of the EBHV program managers, who may have had different levels of familiarity with the capacity and quality of these service referrals. Also, our quality review is limited to the 110 programs represented in the survey. While this sample includes all or the majority of HFI, EHS and NFP sites, it is less representative of the state's PAT programs. The fact that some PAT programs do not operate during the summer months contributed to our inability to engage a more sizable proportion of PAT program managers. As such, our

assessment of the current quality of the EBHV programs being delivered in the state is, at best, preliminary, particularly with respect to PAT.

Finally, we were not able to obtain complete information with respect to the specific catchment areas served by each of the existing EBHV providers nor do we fully understand all the avenues programs utilize to identify and secure their participant base. Although one might assume that home visiting programs, particularly those located in community based service agencies, might draw their participants from the local neighborhood, this is not always the case. Home visitors can and do travel some distance to provide services to families in their homes. Similarly, families may elect to seek services in adjacent communities if local service capacity is insufficient or of poor quality. A critical step in developing the State plan will be better understanding each program's catchment area and the degree to which the current distribution of programs leave certain communities or types of high risk families underserved.

Identifying High Risk Communities

Using administrative data, we were able to identify a number of communities throughout the State that have many of the characteristics commonly associated with elevated rates of child maltreatment and poor outcomes for children. Regardless of how we measured risk, it appears the communities presenting the greatest challenges for young children and their families include:

- Neighborhoods on Chicago's Westside (particularly East and West Garfield Park and Greater Grand Crossing); the Southside (particularly Fuller Park, Washington Park, West Englewood and Englewood); and the far Southside (particularly Riverdale);
- Townships in both the western and southern portions of Cook County (particularly Cicero, Bloom and Calumet townships); the northeastern portion of Lake County (particularly Benton and Zion townships); the northwest portion of McHenry County (particular Chemung township); and the Joliet area in Will County; and
- Several counties throughout the State including a cluster of counties at the far south tip of the State (Alexander, Massac and Pulaski), the south-central counties of Jefferson and Marion, and the central counties of Macon, Vermilion and Knox, and Winnebago County.

Because of the variation in context and resources across these three community clusters, it is difficult to directly compare the need for services across all three groups. The cumulative scores on both our risk index and concentrations of multi-system families suggest greatest risk in certain Chicago neighborhoods. However, these data also underscore that many young children throughout the state are living in families that are characterized by poverty and involvement in multiple services systems including mental health, substance abuse and child welfare. As such, additional resources are needed in all three community clusters, although the structure and capacity of these resources are likely different.

In the absence of being able to better specify the reach and capacity of each existing EBHV program, it is difficult to assess the degree to which current levels of investment are adequate or if they are being allocated in the most efficient manner. While it does appear some communities may have a richer array of services than other areas at equal or higher risk, the distribution of services is only partially a function of a community's level of risk as defined by the types of health and well-being measures available for our analysis. It is possible other dimensions of need such as the proportion of undocumented families living in a community or the loss of other critical family support services may justify the expansion of an EBHV option in a given area. Further, communities will differ in their capacity to implement and sustain an EBHV program including the capacity to secure initial and ongoing funding, to hire and retain a qualified work force and to have access to the full range of supportive and therapeutic services program participants may need. Communities that have robust leadership within its school districts, local public agencies and non-profit organizations may find it easier to expand services than communities without this level of leadership. In determining how best to allocate new resources or realign existing resources, it will be important for the state to build on this initial assessment and obtain more comprehensive information on the characteristics of local populations and the capacity of local service systems before committing to expanding programs in any given community.

Potential Challenges

The best strategy for allocating funding from the Maternal, Infant, and Early Childhood Home Visitation Program is far from self-evident. Findings from the current needs assessment as well as findings cited in the other needs assessments we reviewed underscore four major challenges in moving forward. Each of these issues is outlined below.

Building a More Coordinated and Robust Service Response at the Community Level

Achieving the desired outcomes identified in the Maternal, Infant, and Early Childhood Home Visitation Program will require both the expansion of home based interventions as well as improvements within local service networks. Regardless of the communities in which it elects to focus, the state will need to pay particular attention to the capacity of local organizations within each community to implement and sustain EBHV programs with fidelity and the degree to which local service networks can offer the types of service options that will be required for these home based interventions to realize maximum impacts. Preliminary results generated through this needs assessment suggest that in many communities throughout the State local service capacity to support EBHV programs is limited. Unless improvements can be realized in the availability and quality of local services in many critical areas including basic support services as well as therapeutic services, it is unclear if expanding the availability of EBHV

programs will achieve the anticipated changes in core outcomes, particularly in the highest risk communities.

The location of this program within the context of the State's health system, particularly in light of broader health care reform efforts, offers an excellent opportunity to improve the capacity of home visitation programs by linking families with a primary care provider and improving coordination with other medical and preventive services funded through Title V. One of the key attributes of the home visitation models being implemented in the State is their commitment to linking participants with critical services including, among others, preventive health care, mental health services and services for children with special medical problems or developmental needs. Although representatives of agencies funding and providing these services already participate in statewide and local early childhood collaborations, the needs assessment suggests more intentional efforts are needed to fully engage these representatives in the planning and implementation of home based interventions which target pregnant women and new borns. This level of increased engagement will be particularly important in addressing the needs of new parents facing substance abuse issues as discussed below.

Strengthening Infrastructure Capacity

Both the current needs assessment and the Title V assessment suggest the need for a more concerted effort to improve the state's infrastructure around service delivery, particularly in the areas of data management and collaboration. Although Illinois is unique in its ability to draw together information on families engaged in multiple public agencies through the Integrated Data System operated by Chapin Hall, information on the capacity and quality of home based interventions and other key ancillary services is far more diffused. In order to insure that home based interventions are reaching those at greatest need and providing access to the other medical, therapeutic and supportive services new parents and young children require, more accurate information is needed on current service capacity and performance. Specifically, investments in this area would be enhanced if the State developed a single data management system that would document the characteristics of participants enrolling in these programs, their service experiences including the extent to which they need and receive additional services and support, and their initial and long term outcomes. Such information would provide a far more accurate picture than is currently possible of the system's current service capacity, its ability to engage and retain its intended population, and the extent to which targeted outcomes are being achieved across all elements of the target population. The system also would identify the unmet or emerging service needs among new parents in a more timely and responsive manner, thereby providing policy makers with stronger empirical evidence for determining where to expand or shift current investments.

In addition to building data capacity, it will be important to engage new partners in existing early childhood collaboratives. Both the CAPTA and Head Start assessments as well as our survey of program managers noted the importance of fostering new partnerships with agencies serving emergent immigrant populations particularly in suburban and downstate communities as well as the need to establish more formal linkages with agencies serving the homeless population and those needing emergency services to meet concrete needs. Such linkages are important not only for maximizing the capacity of home visitors to access the full range of services program participants may need but also for capitalizing on the expertise and knowledge of those who work with these specific populations on a daily basis. By nurturing these relationships, the early intervention field has the opportunity to develop a more intentional focus on parenting issues and early child development within these broader service delivery systems.

Addressing Growing Population Diversity and Emerging Needs

Developing culturally appropriate and responsive services as well as prioritizing communities and populations in greatest need of support will be increasingly difficult in Illinois. As documented in our assessment and the other needs assessments we reviewed, Illinois is home to a broad range of ethnic and cultural groups. Although the city and more urbanized areas of the state have always had diverse populations, this diversity is now found throughout the state, including many suburban and rural areas. This diversity has at times created tension in communities in which local service systems and residents are unfamiliar with the different cultural norms and values that can influence parent child relationships and social interactions within these groups. As such, ethnic families moving into these communities may become isolated and unable to access the formal and informal supports a community might offer them. From a programmatic perspective, staff qualifications and service content may need to be reconsidered among programs working with these new populations. Because the ultimate success of home visitation programs can often hinge on the ability of the home visitor to establish a strong and respectful relationship with participants, it will become increasingly important for home visitation programs to build capacity to respond to the increased diversity among the new parents they serve. At a minimum, these changes will involve hiring bilingual staff that offer proficiency in a number of languages (including Spanish as well as Arabic, various Eastern European and Asian languages) and developing engagement methods that can attract and retain these populations.

As with all areas of the country, Illinois is facing significant economic challenges. As reported earlier, the unemployment rate exceeds the national average in almost every region of the state. The lack of the jobs has created pockets of new poverty in many communities and has created financial stress on a growing segment of the new parent population. At the same time, the economic downturn has limited the ability of the State to continue investments in many service areas, resulting in a reduction in services at the same

time demand for assistance is growing. Many of the home visitation program managers who responded to our survey have been forced to reduce their own service capacity and deal with reductions in availability of other local services. Although certain communities have higher concentration of risk and service needs than others, all communities and parts of the state are in need of additional resources to meet the needs of their residents who are pregnant or parenting young children. The challenge will be how to balance the State's ability to address the highest risk communities without further compromising service capacity in other areas of the State.

Unique Challenges of the Substance Abuse Population

One of the most important features of the Maternal, Infant and Early Childhood Home Visitation Program is the explicit focus on the issue of substance abuse. The importance of addressing this need among pregnant women and those caring for young children has long been recognized by those developing and implementing intensive home based interventions. As noted by several home visitation program managers and direct service staff, successfully engaging and retaining women dealing with substance abuse issues has been challenging. Among substance abuse treatment programs, a corresponding challenge has emerged in terms of providing the ongoing support their clients need around parenting and child development issues, particularly after they leave intensive treatment programs. To better identify and address the needs of this specific subgroup of pregnant women and new parents, increased investments may be needed in both systems. Areas in which capacity building might be needed include: placement of assessment counselors within existing EBHV models to facilitate the appropriate identification of substance abuse issues among those accessing these models and to develop collaborative relationships with those agencies that serve women and young children; the expansion of in-patient services for women identified with this problem within the current network of substance abuse treatment programs; and the expansion of follow-up services for women who graduate from these programs in order to facilitate the provision of appropriate aftercare services for their young children.

Next Steps

This document represents an initial attempt to quantify the scope of the problem, identify those communities and populations facing high risk for poor child outcomes, and assess the current capacity of local service systems to respond to these needs. Although the needs assessment identified areas of unmet need, the process also articulated several strengths within the current structure that will provide a strong foundation on which to build capacity. These elements include:

- A strong history of using administrative data in and across state agencies to identify emerging issues and monitor policy and program impacts;

- An existing Early Learning Council that has initiated and fostered a set of working relationships among those in both the public and private sector working to improve outcomes for young children and their families;
- A Home Visit Task Force that has advanced joint efforts across agencies and among the various home visitation models being implemented in the state to create the initial framework for a coordinated system;
- Participation in the Children's Bureau's Supporting Evidence-Based Home Visiting Initiative which has further strengthened the State's commitment to investing in the infrastructure necessary to expand EBHV programs throughout the State including the expansion of training opportunities for home visitors, improving data collection and monitoring, and increasing public awareness around the importance of serving families with children 0-3; and
- A robust network of local coalitions committed to strengthening local capacity and developing more integrated service networks at the community level.

Drawing on these resources, the Home Visit Task Force, in partnership with state agency leadership, can begin the process of finalizing the scope and content of the final statewide plan. Among the issues to be determined in the next several months will be selecting specific communities, determining which EBHV programs provide the most appropriate fit with the characteristics and presenting problems of new parents and existing service networks in these communities and better aligning other state investments in ways that will improve service access and enhance child outcomes.

Appendix A

Program Manager Survey

Program Manager Survey

Many organizations provide a diverse array of service models. The questions below pertain to your implementation of _____ (List specific program)

Funding Trends and Impacts

1. For each of the following revenue sources please indicate if you currently draw on these types of funds to support this home visitation program and, if so, roughly what proportion of your operating budget for this program do they represent.

	Source of Support		**Percentage of Budget From Source**		
	Yes	**No**	**< 25 %**	**25-50%**	**Over 50%**
State Department of Human Services (DHS)					
State Department of Children and Family Services (DCFS)					
State Board of Education (ISBE)					
State Department of Healthcare and Family Services (DHFS)					
County or City funding sources (If Chicago: CPS funding?)					
Private funding (United Way, Foundations)					
Other:					

2. Recent reductions in state funding levels or delays in payments have impacted many social service programs. How have these reductions impacted your operations over the past year?

___ No significant impact
___ Moderate impact
___ Substantial impact

3. If you have experienced a moderate or substantial impact, which of the following actions have you had to take to compensate for these and other revenue loses. (Check all that apply)

___ Laid off staff (number laid off___)
___ Reduced hours of existing staff
___ Reduced service intensity/dosage
___ Increased home visitor caseloads
___ Reduced professional development budgets
___ Reduced or eliminated other services or supports to your home visit clients
___ Other: _____

Service Capacity

4. What is your program's full service capacity when you are fully staffed and funded?

___ # of families

5. How many families are currently enrolled in your home visitation program?

___ # of families

6. What is the total number of families you served in FY 2010 (July 2009 – June 2010)?

___ # of families

7. What is the total number of families you served in FY 2009 (July 2008 – June 2009)?

___# of families

8. When your caseload is full, do you offer families that are referred to you the option of being placed on a "wait-list", in case you do have an opening?

___ No
___ Yes

IF YES: 9. How many families are currently on the wait-list? _____

10. What is the average time a family will spend on the wait-list?
___ less than one week
___ more than a week but less than a month
___ over a month

11. Are families on the wait-list provided any services?
___ No
___ Yes (Provide examples: _____)

12. Roughly what proportion of the parents/families enrolled in your program demonstrate the following characteristics?

Characteristic	% of Caseload With Characteristic
Non-English speaking	
Undocumented immigrants	
Teen parents (under 20 years of age)	
Single parent	
Low income (e.g., WIC eligible)	
Lacking a high school diploma/GED	
Homeless or unstable housing	
Unemployed and seeking work	
Socially isolated	
Lacking auto/transportation resources	
Active substance abuse issue	
Clinical depression/mental health issues	
Domestic violence issues	
Infant enrolled in early intervention (Part C)	
Parent with developmental delay	
Serious physical health issue	

13. What is your geographic service area or the community in which most of your program participants live? _____

14. How would you rate the following services in the community from which you draw your families?

Condition	**Generally adequate**	**Somewhat of a challenge**	**Considerable challenge**
Public transportation			
Crime or community violence			
Local healthcare service and resources			
Local social services and family supports			
Community social cohesion/social efficacy			
Parks, libraries and community centers			
Job opportunities for families			
Early childhood education opportunities			
Labor market for program staff			
Child care			
Other:			
Other:			

15. What is the average distance your home visitors have to travel to meet with program participants in their homes?

____ Less than a mile
____ 1 to 5 miles
____ 6 to 15 miles
____Over 15 miles

16. How frequently are families in your program referred to the following services?

Service category	Often	Occasionally	Rarely
Primary health care			
Mental health services for parent			
Substance abuse treatment for parent			
Domestic violence counseling or shelter			
Services for parental developmental delays			
Homelessness			
Basic infant and household items			
Infant and early childhood mental health			
Assistance with child developmental delays			
Income maintenance services			
Employment counseling/job assistance			
Child care			
Other:			
Other:			

17. How would you rate the general quality and accessibility of these services?

	Overall Quality			Accessibility	
Service category	**Very good**	**Adequate**	**Lacking**	**≤ 5 miles**	**>5 miles**
Primary health care					
Mental health services for parent					
Substance abuse treatment for parent					
Domestic violence counseling or shelter					
Services for parental developmental delays					
Homelessness					
Basic infant and household items					
Infant/ early childhood mental health					
Help with child developmental delays					
Income maintenance services					
Employment counseling/job assistance					
Child care					
Other:					
Other:					

18. Over the coming, year do you anticipate that referral resources in each of these areas will increase, decrease, or remain constant?

Service category	Increase	Remain Stable	Decrease
Primary health care			
Mental health services for parent			
Substance abuse treatment for parent			
Domestic violence counseling or shelter			
Services for parental developmental delays			
Homelessness			
Basic infant and household items			
Infant and early childhood mental health			
Assistance with child developmental delays			
Income maintenance services			
Employment counseling/job assistance			
Child care			
Other:			
Other:			

Service Implementation

19. How common is it for participants in your program to be referred from the following sources?

Referral source	Often	Sometimes	Rarely	Never
Prenatal clinics, public health clinics, WIC office				
Individual medical providers				
Child care centers, schools				
Other program participants, local residents				
Self-referrals				
Families identified through program outreach efforts				
Other:				

20. Of families offered enrollment in your program, what proportion refused enrollment?

___ Less than 10%
___ 10 to 25%
___ More than 25%

21. Please provide a general estimate of your home visit completion rate (e.g., number of completed home visits divided by the number of expected home visits): _____

22. (IF PROGRAM CANNOT PROVIDE THIS DATA) Of the families who enrolled in your program, roughly what proportion received at least 50% of the home visits that were offered them?

___ 90% or more of families
___50 to 89% of families
___ Less than 50% of families

23. Do you do any of the following on a regular basis? (Check all that apply)

____ Have families complete a satisfaction form at the end of each home visit
____ Solicit feedback from families on a regular basis during enrollment
____ Solicit feedback from families at the time services are terminated

24. How has this information informed/influenced your delivery of home visitation services? (check all that apply)

____ Minimal impact (feedback has been too variable, not specific enough to be helpful)
____ Impact on training of home visitors
____ Impact on program content and topics covered during the visits
____ Impact on types of referrals/linkages you have established with other local providers
____ Other: _____

25. Does your program have a credential, commendation or other formal designation related specifically to the home visitation program we are discussing?

____ No
____ Yes

26. If yes, please indicate which model(s)

___ Healthy Families America Credential
___ Parents as Teachers Commendation
___ Nurse Family Partnership approved program plan from NFP NSO
___ Early Head Start Federal Review with no deficiencies
___ Other: _____

27. Home visitor information – for each home visitor/supervisor currently employed by your HV program please provide the following information:

	Role	**FT/PT**	**Highest degree**	**Months in this job**	**Experience in home visiting**	**Certified in model Yes/No**	**Bilingual Yes/No**	**Race**
Worker 1								
Worker 2								
Worker 3								
Worker 4								
Worker 5								
Worker 6								
Worker 7								
Worker 8								
Worker 9								
Worker 10								

Role = home visitor, supervisor, both
FT/PT = Full time or part time status
Highest degree = Ph.D., Masters, BA, Less than BA
Months in Job = number of months employed in current program
Experience = months experience with any home visitation program
Certified = is worker formally trained or certified in delivering this model?
Bilingual = is worker bilingual and able to work with non-English speaking families without a translator?
Race = White, Black, Hispanic, Other

28. Methods and frequency of supervision

	Weekly	**2 -3 times a month**	**Monthly**	**Less than monthly**	**Never**
Individual meetings with home visitor					
Group supervision/case reviews					
Direct observations in the home					

29. Over the past year, how many professional development and in-service training opportunities have you made available to your direct service staff and how many staff participated?

Training Opportunities	**Number sessions offered**	**Number staff attending**
On-site training opportunities		
Off-site training opportunities (other than the Ounce of Prevention Training Institute)		
Training via a webinar or teleconference		

On-site training = Includes educational opportunities presented by program staff to their colleagues as well as instances in which a consultant or expert was brought to the program to meet with staff

Off-site training = Includes educational opportunities offered to staff that are not held at the program offices such as attendance at a conference or professional meeting or a consultant/expert lecture. Please do not include the training your program staff received from the Ounce of Prevention Fund.

Training via a webinar or teleconference = Includes opportunities for staff to participate in a web-based training or teleconference.

30. How often (as a percentage of all referrals you make) do you use the following strategies to determine if a family has accessed a referral you have offered them?

	90% +	**89 – 50%**	**49 - 25%**	**< than 25%**	**Never**
Contact families to specifically follow-up on each referral					
Informally hear from families that they have followed through					
Contact the referral agency to determine if the family has contacted them					

31. Is your organization active in any local collaborations around the issue of early intervention or services for infants and young children and their families (e.g., the AOK network, Strengthening Families network, etc)?

___ No
___ Yes

32. If YES, which ones and what were your primary reasons for joining?

Name of Network	**Purpose for joining (e.g., coordinating referrals; sharing resources; developing new programs; advocacy; etc.)**

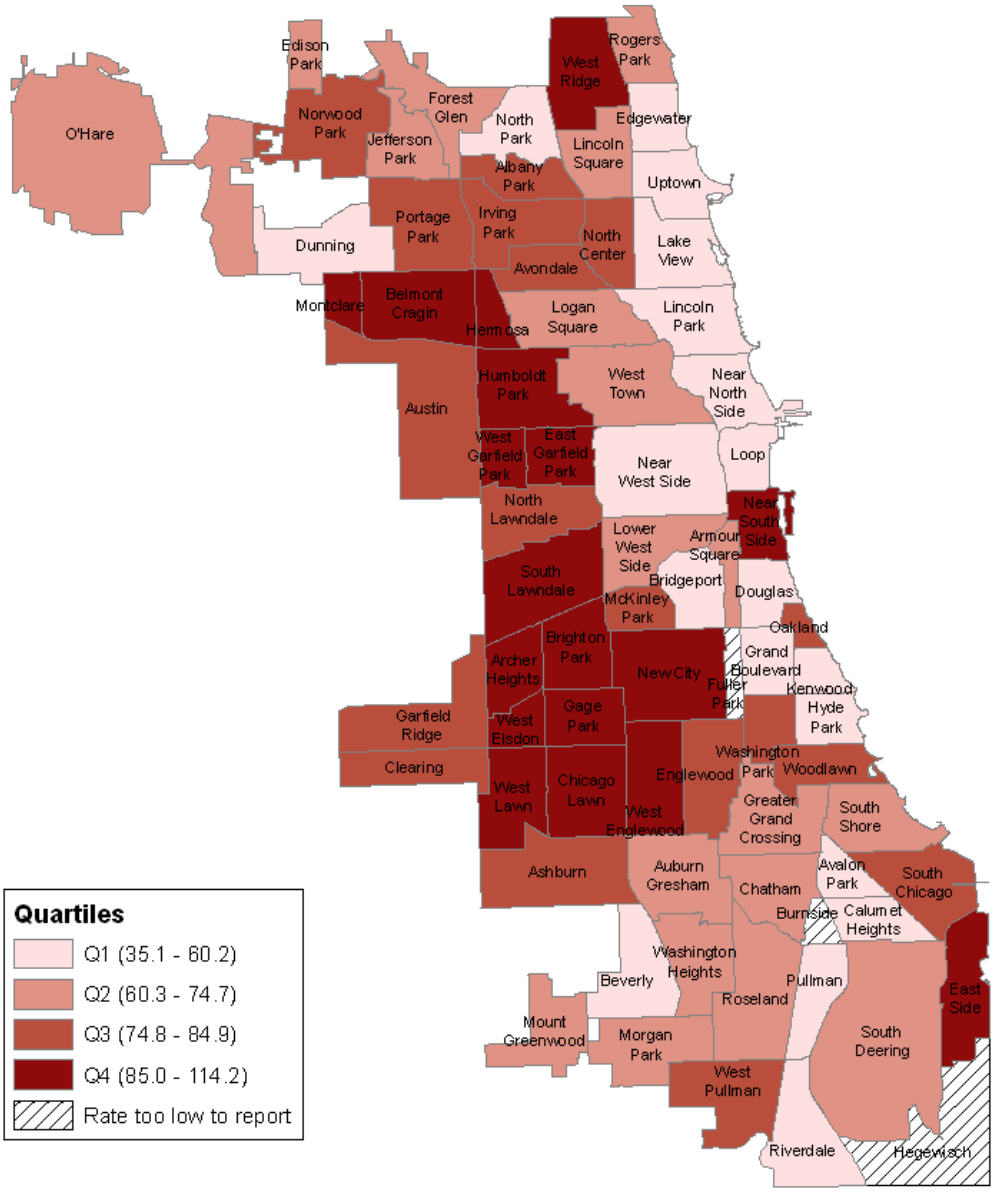
33. How frequently in the past 12 months have you participated in the following activities with other local service providers in your community, town or county?

Activity	**Participated**	**Played a Leadership Role**
Improving service collaboration		
Developing shared training across staff		
Joint program evaluation and assessment efforts		
Expanding funding opportunities/funding levels		
Advocating for new policies/ programs		
Shared physical location other resources		
Developing public education/awareness plans		
Other:		
Other:		

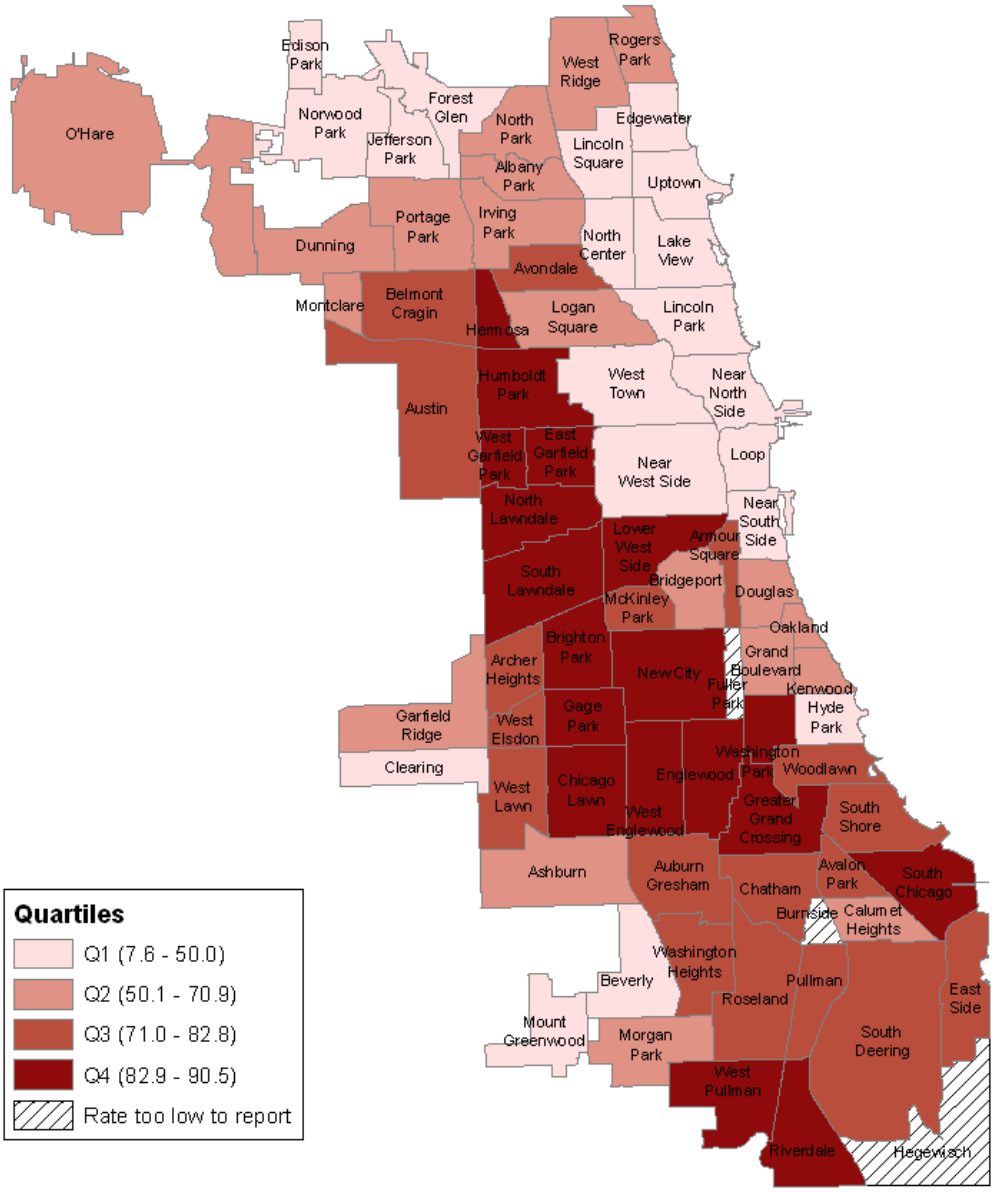
Appendix B

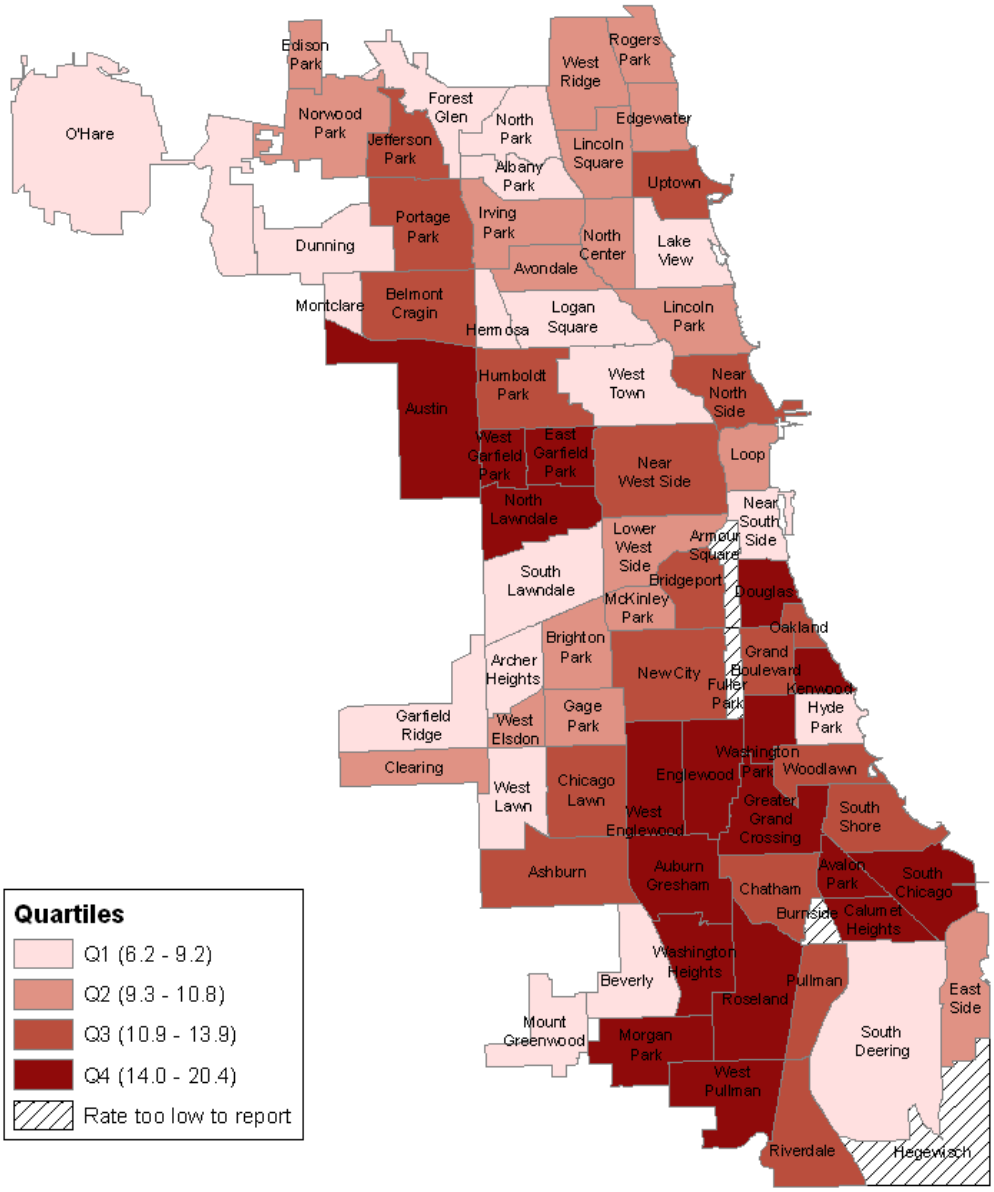
Risk Indicator Maps

City of Chicago: Community Areas

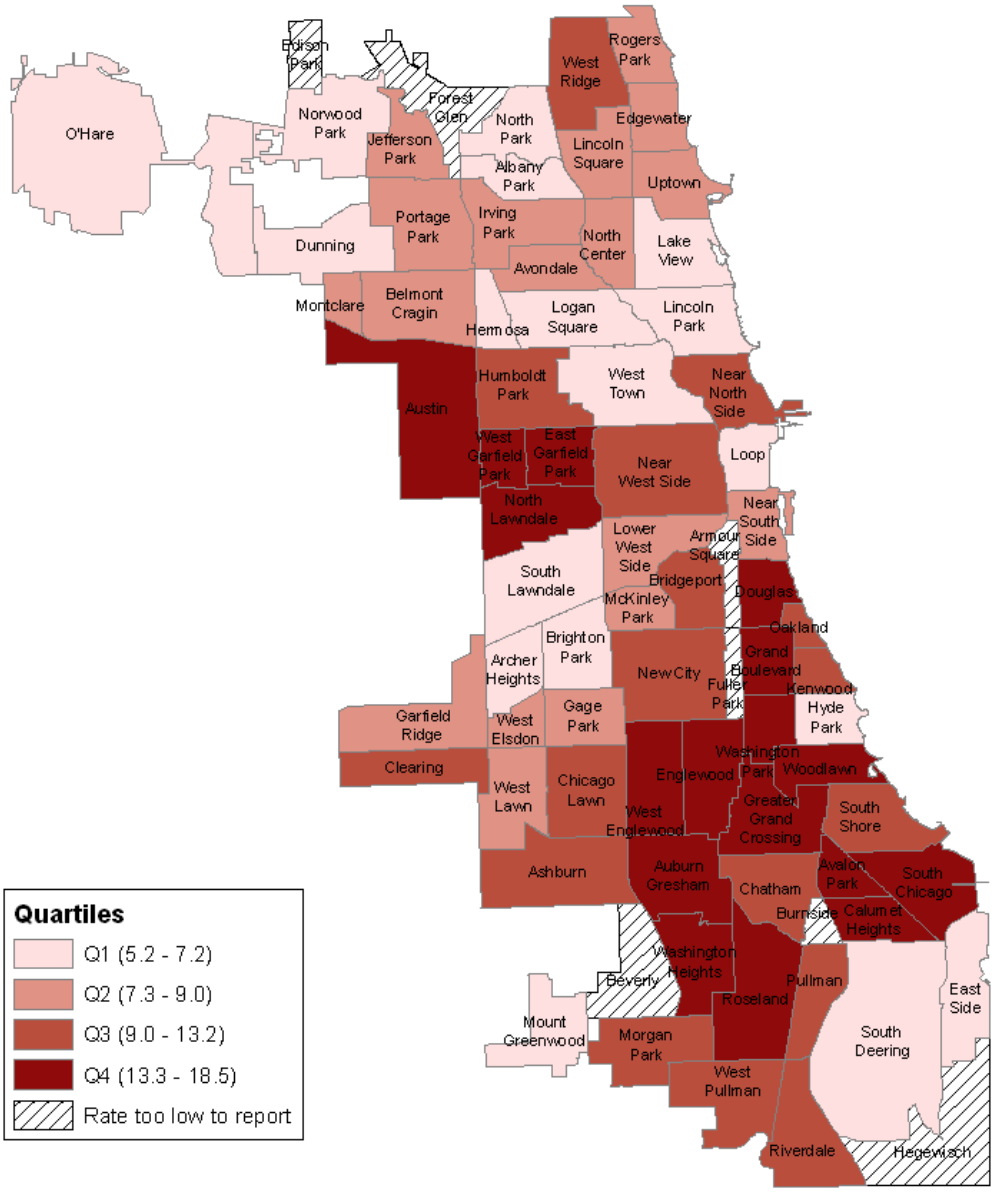

City of Chicago: Community Areas
Birth Rate
Edison Park
Rogers Park
West Ridge
O'Hare
Norwood Park
Forest Glen
North Park
Edgewater
Jefferson Park
Lincoln Square
Albany Park
Uptown
Portage Park
Irving Park
Dunning
North Center
Lake View
Avondale
Montclare
Belmont Cragin
Logan Square
Lincoln Park
Hermosa
Humboldt Park
West Town
Near North Side
Austin
West Garfield Park
East Garfield Park
Near West Side
Loop
North Lawndale
Near South Side
Lower West Side
Armour Square
South Lawndale
Bridgeport
Douglas
McKinley Park
Oakland
Brighton Park
Grand Boulevard
Archer Heights
New City
Fuller Park
Kenwood
Hyde Park
Garfield Ridge
West Elsdon
Gage Park
Washington Park
Woodlawn
Clearing
Englewood
West Lawn
Chicago Lawn
Greater Grand Crossing
South Shore
West Englewood
Ashburn
Auburn Gresham
Avalon Park
South Chicago
Chatham
Burnside
Calumet Heights
Washington Heights
Beverly
Pullman
Roseland
East Side
Mount Greenwood
Morgan Park
South Deering
West Pullman
Riverdale
Hegewisch
Quartiles
Q1 (35.1 - 60.2)
Q2 (60.3 - 74.7)
Q3 (74.8 - 84.9)
Q4 (85.0 - 114.2)
Rate too low to report

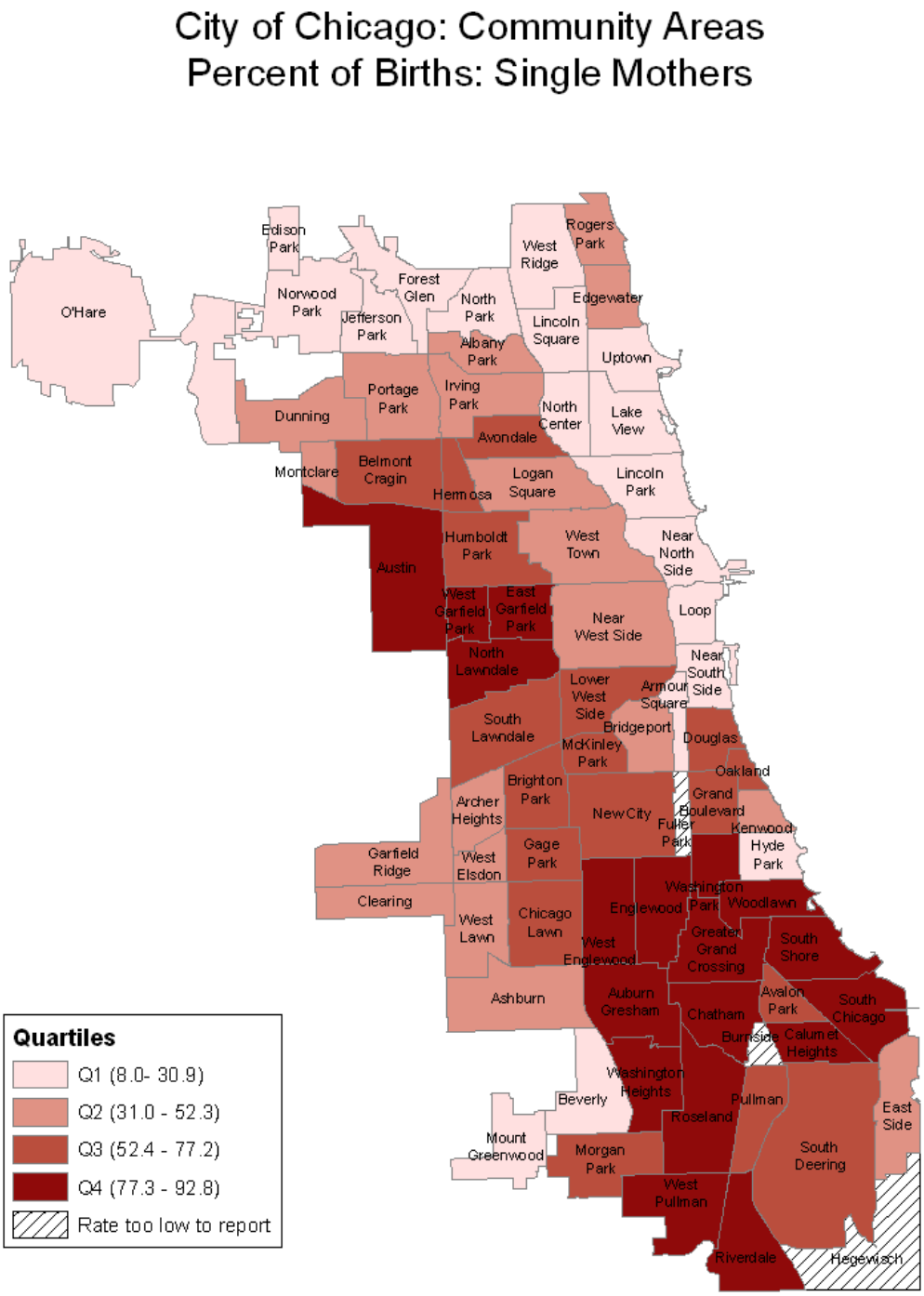
City of Chicago: Community Areas
Percent of Births: Medicaid Paid



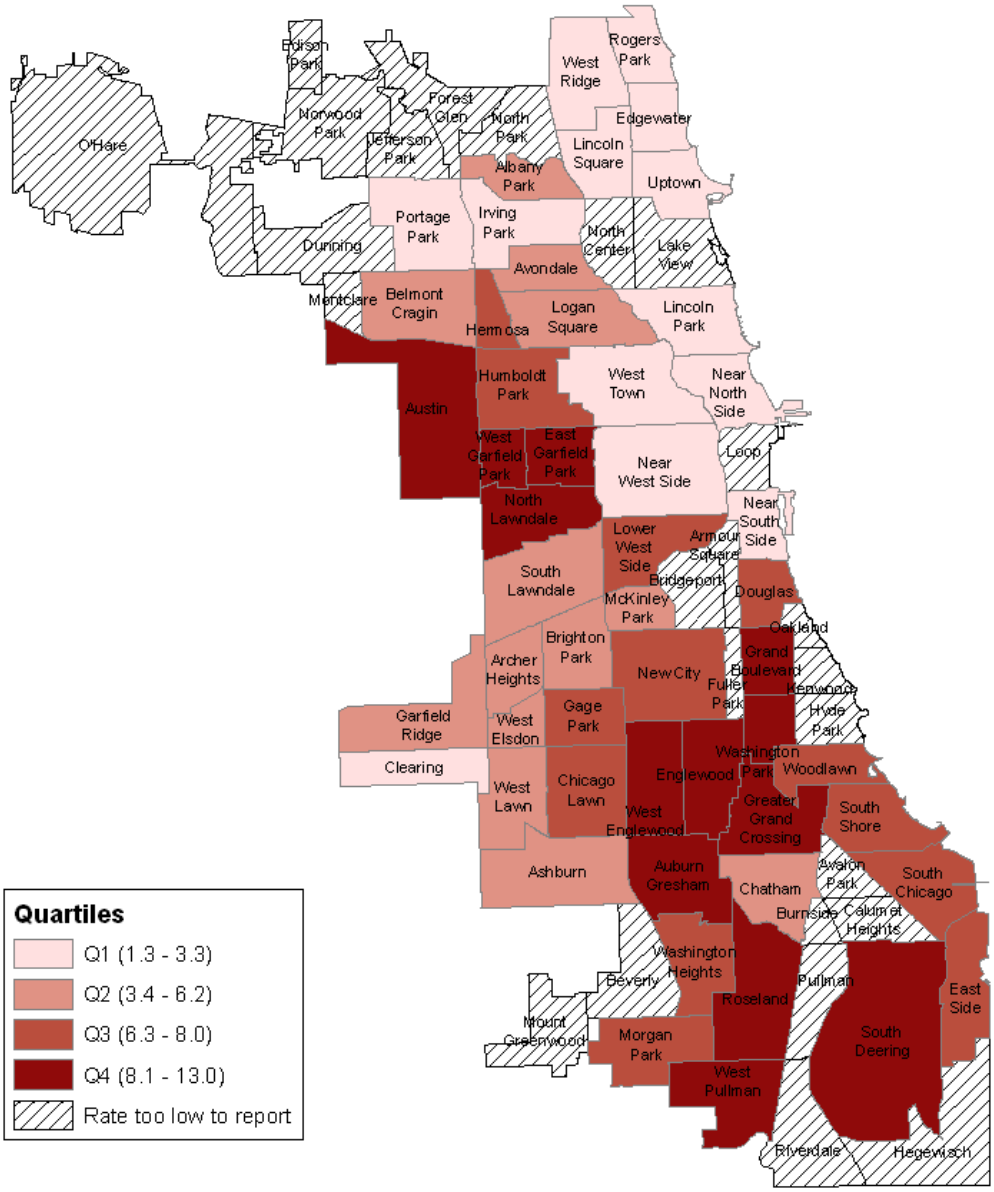

City of Chicago: Community Areas
Percent of Births: Premature
Edison Park
Rogers Park
West Ridge
O'Hare
Norwood Park
Forest Glen
North Park
Edgewater
Jefferson Park
Lincoln Square
Albany Park
Uptown
Portage Park
Irving Park
Dunning
North Center
Lake View
Avondale
Montclare
Belmont Cragin
Logan Square
Lincoln Park
Hermosa
Humboldt Park
West Town
Near North Side
Austin
West Garfield Park
East Garfield Park
Near West Side
Loop
North Lawndale
Near South Side
Lower West Side
Armour Square
South Lawndale
Bridgeport
Douglas
McKinley Park
Oakland
Brighton Park
Grand Boulevard
Archer Heights
New City
Fuller Park
Kenwood
Hyde Park
Garfield Ridge
West Elsdon
Gage Park
Washington Park
Clearing
Englewood
Woodlawn
West Lawn
Chicago Lawn
Greater Grand Crossing
South Shore
West Englewood
Ashburn
Auburn Gresham
Avalon Park
South Chicago
Chatham
Burnside
Calumet Heights
Washington Heights
Beverly
Pullman
Roseland
East Side
Mount Greenwood
Morgan Park
South Deering
West Pullman
Riverdale
Hegewisch
Quartiles
Q1 (6.2 - 9.2)
Q2 (9.3 - 10.8)
Q3 (10.9 - 13.9)
Q4 (14.0 - 20.4)
Rate too low to report

City of Chicago: Community Areas
Percent of Births: Low Birth Weight

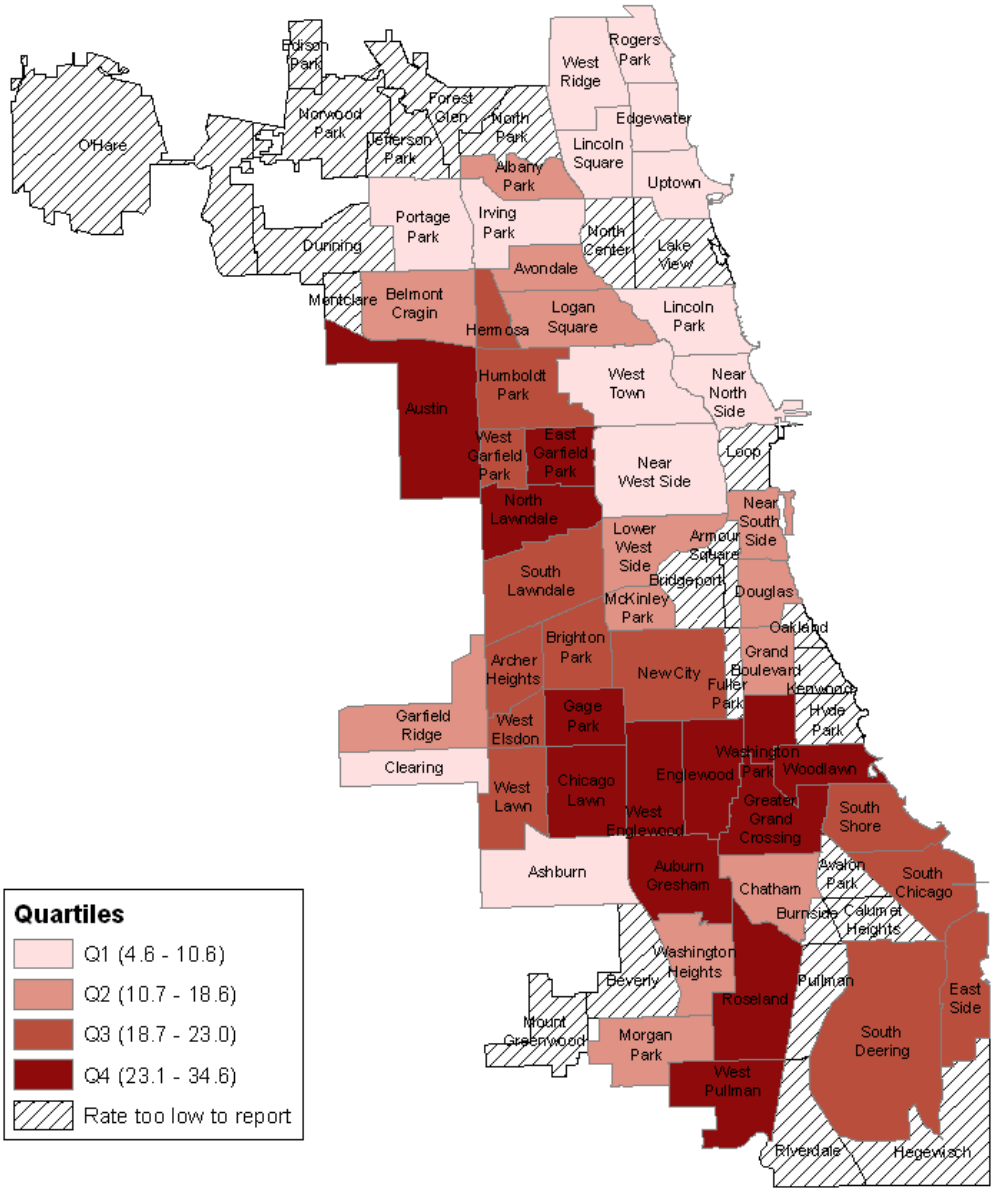



City of Chicago: Community Areas
Percent of Births: Single Mothers
Edison Park
Rogers Park
West Ridge
O'Hare
Norwood Park
Forest Glen
North Park
Jefferson Park
Edgewater
Lincoln Square
Albany Park
Uptown
Portage Park
Irving Park
Dunning
North Center
Lake View
Avondale
Montclare
Belmont Cragin
Logan Square
Lincoln Park
Hermosa
Humboldt Park
West Town
Near North Side
Austin
West Garfield Park
East Garfield Park
Near West Side
Loop
North Lawndale
Near South Side
Lower West Side
Armour Square
South Lawndale
Bridgeport
Douglas
McKinley Park
Oakland
Brighton Park
Grand Boulevard
Archer Heights
New City
Fuller Park
Kenwood
Hyde Park
Garfield Ridge
West Elsdon
Gage Park
Washington Park
Clearing
Englewood
Woodlawn
West Lawn
Chicago Lawn
Greater Grand Crossing
South Shore
West Englewood
Ashburn
Auburn Gresham
Avalon Park
South Chicago
Chatham
Burnside
Calumet Heights
Washington Heights
Beverly
Pullman
Roseland
East Side
Mount Greenwood
Morgan Park
South Deering
West Pullman
Riverdale
Hegewisch
Quartiles
Q1 (8.0- 30.9)
Q2 (31.0 - 52.3)
Q3 (52.4 - 77.2)
Q4 (77.3 - 92.8)
Rate too low to report

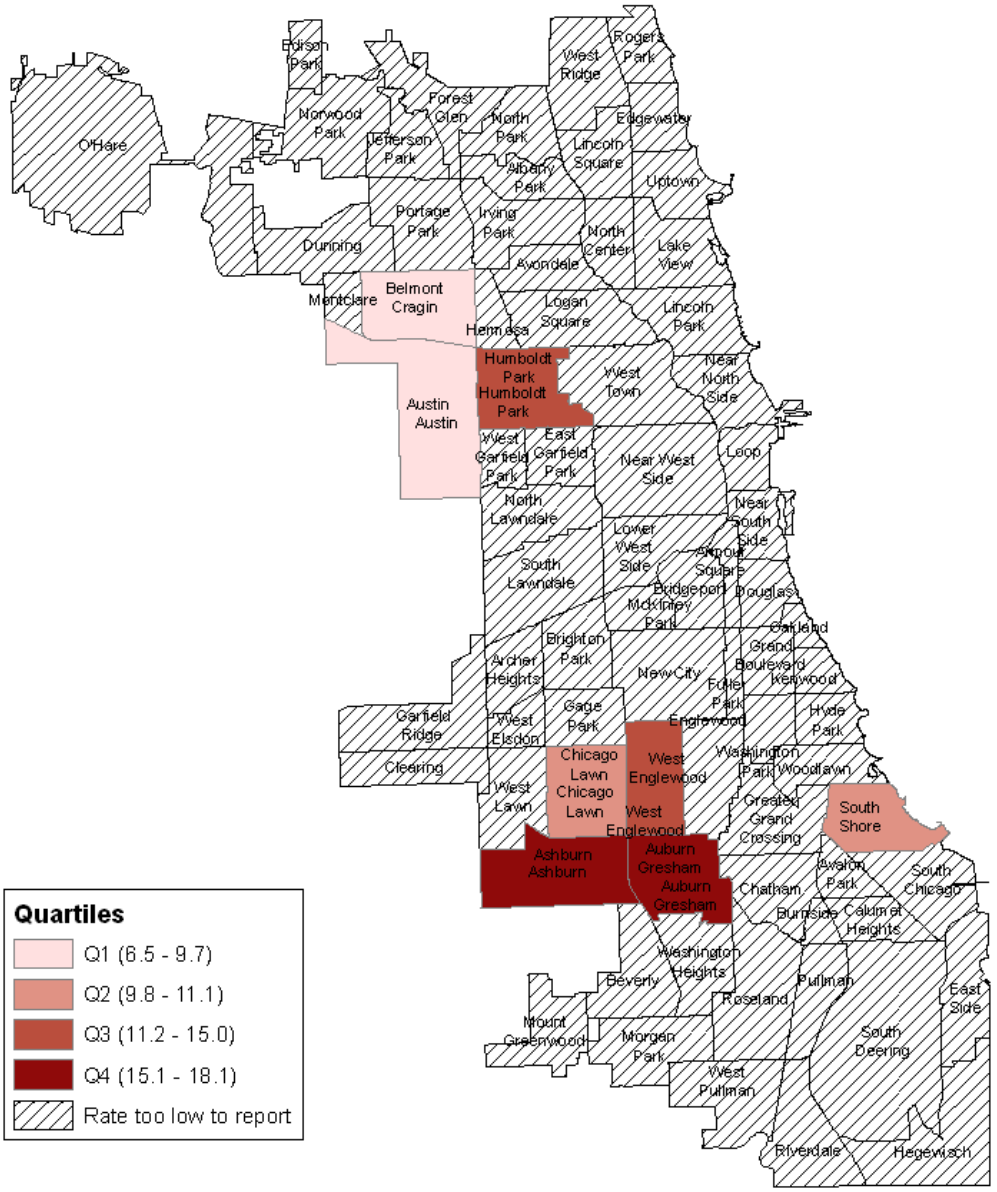
City of Chicago: Community Areas
Percent of Births: Teenage Mothers (<17)



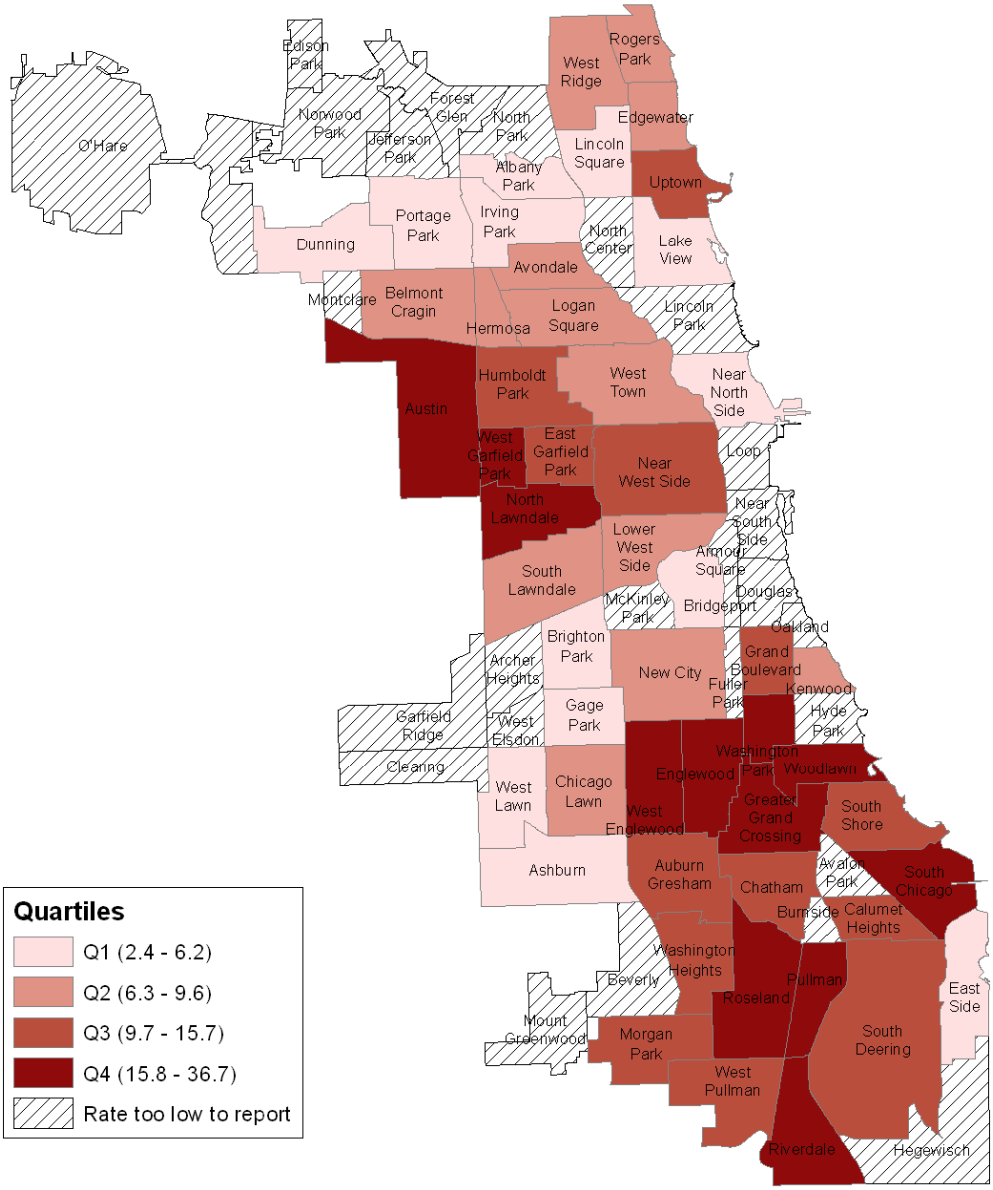
City of Chicago: Community Areas
Teen Birth Rate



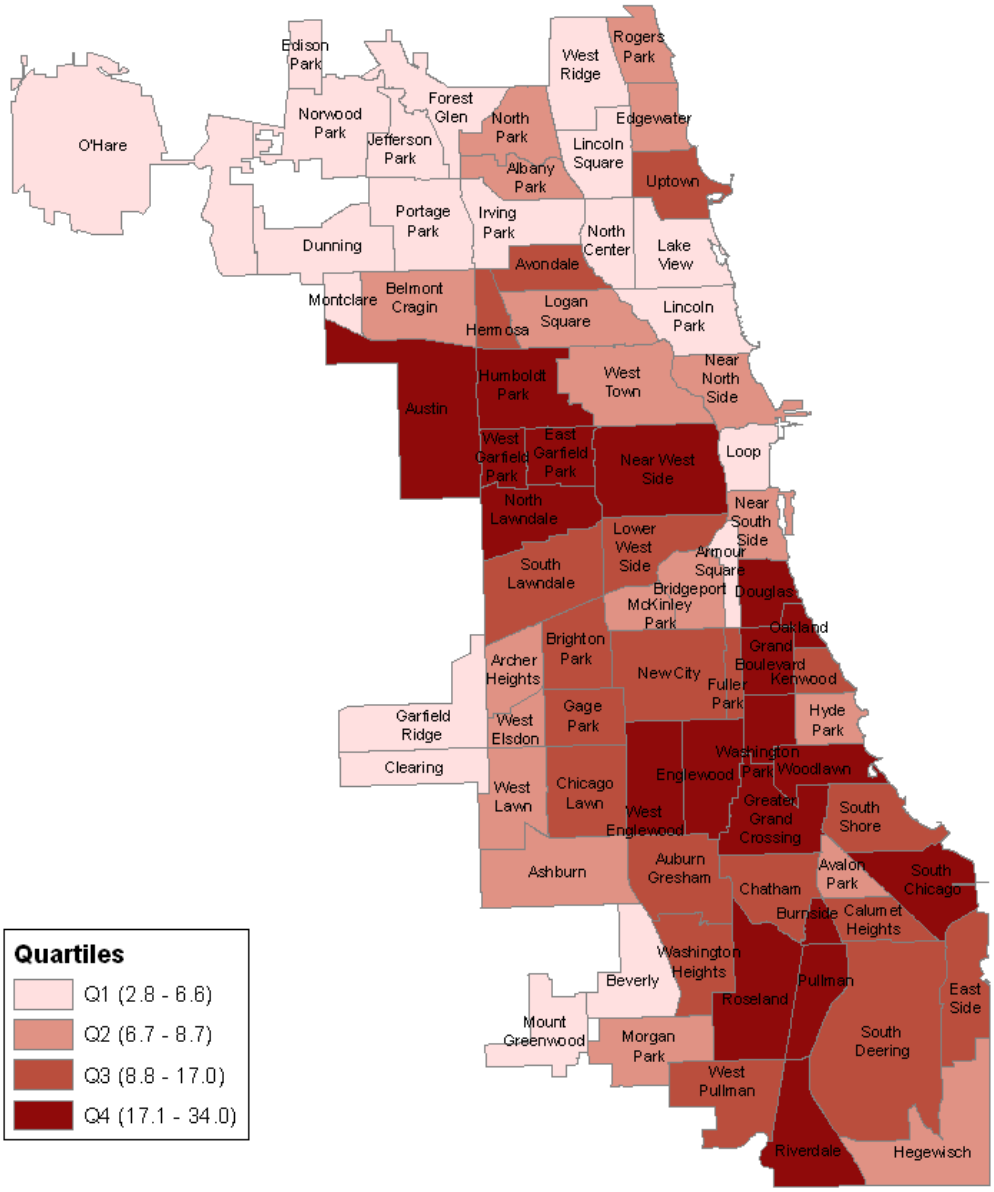
City of Chicago: Community Areas
Infant Mortality Rate



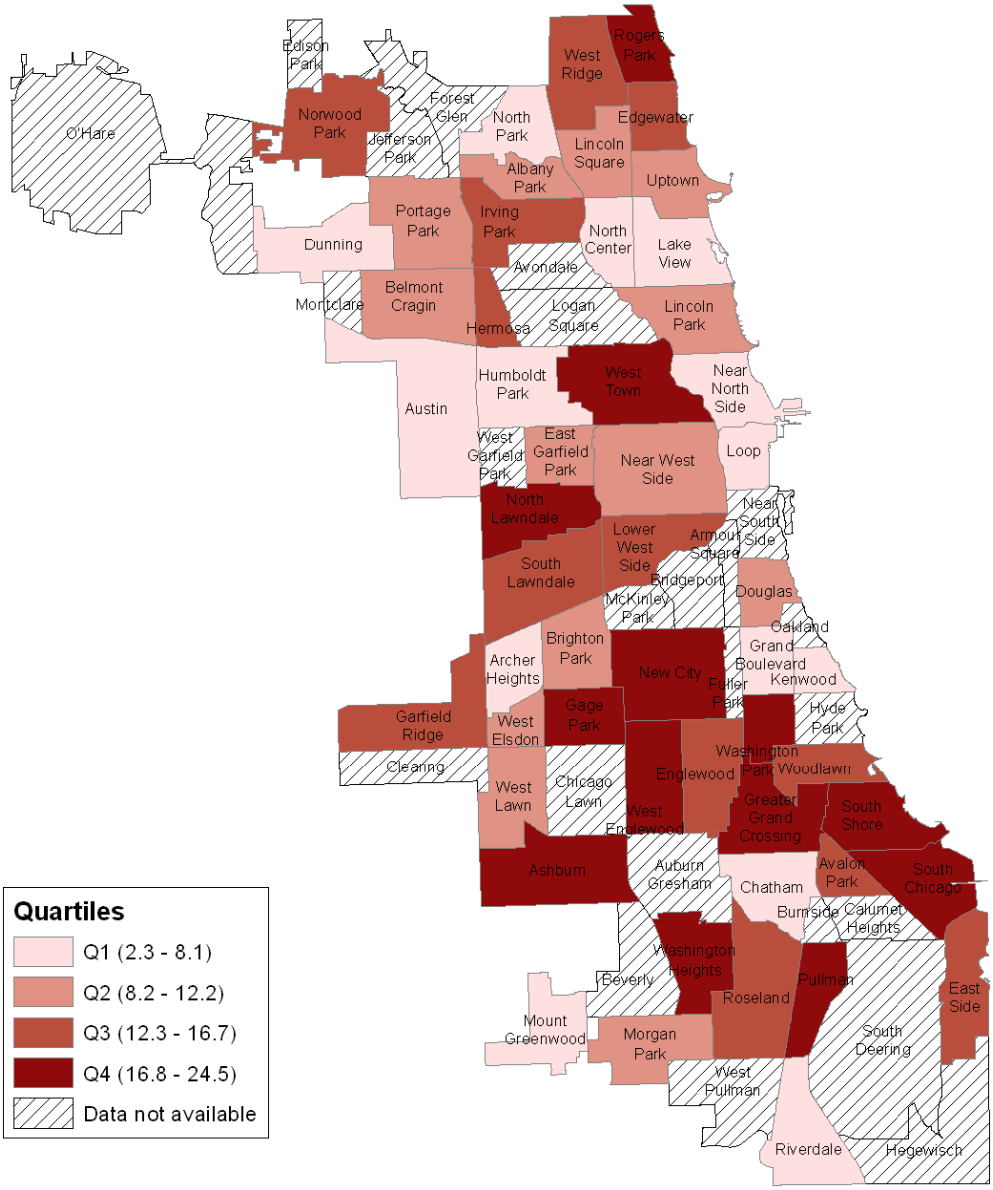
City of Chicago: Community Areas
Child Abuse and Neglect Rate



City of Chicago: Community Areas Unemployment Rate

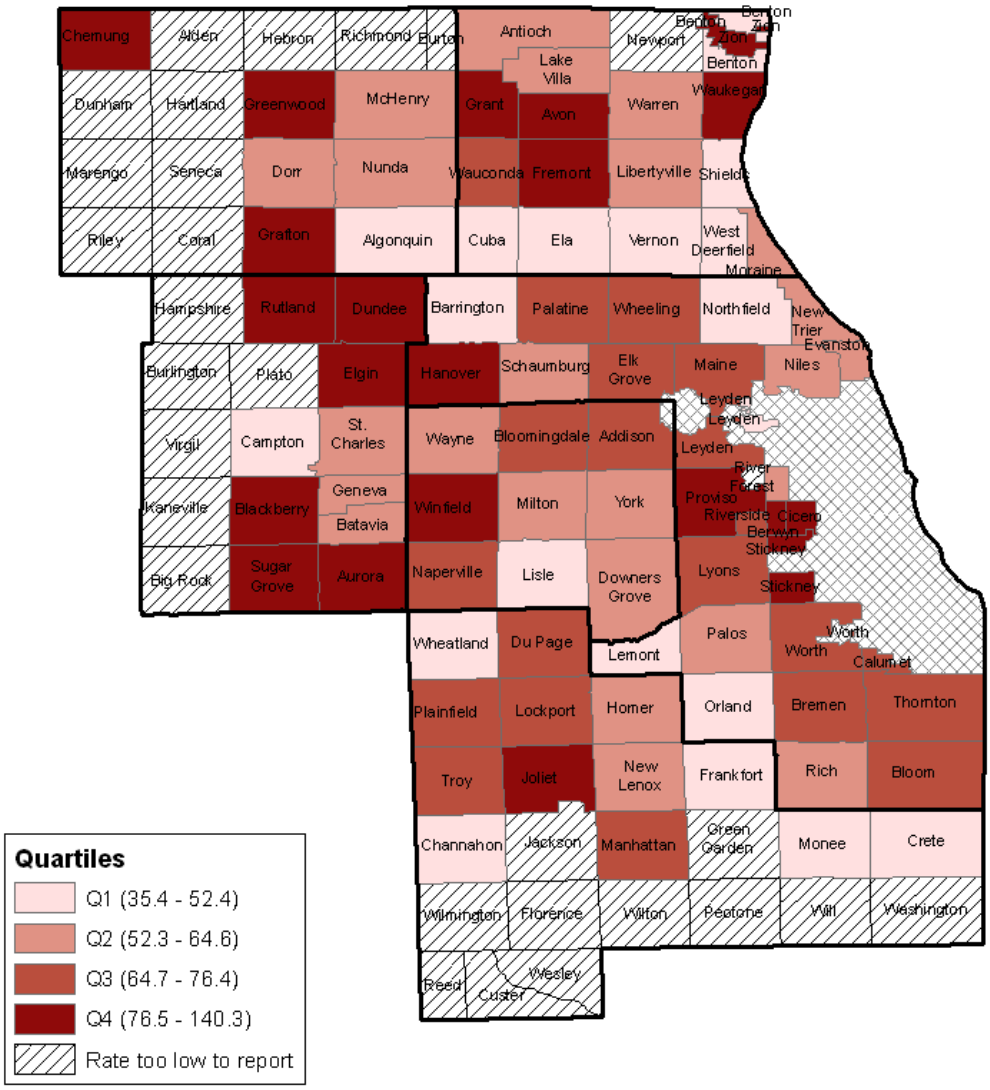


City of Chicago: Community Areas
High School Dropout Rate

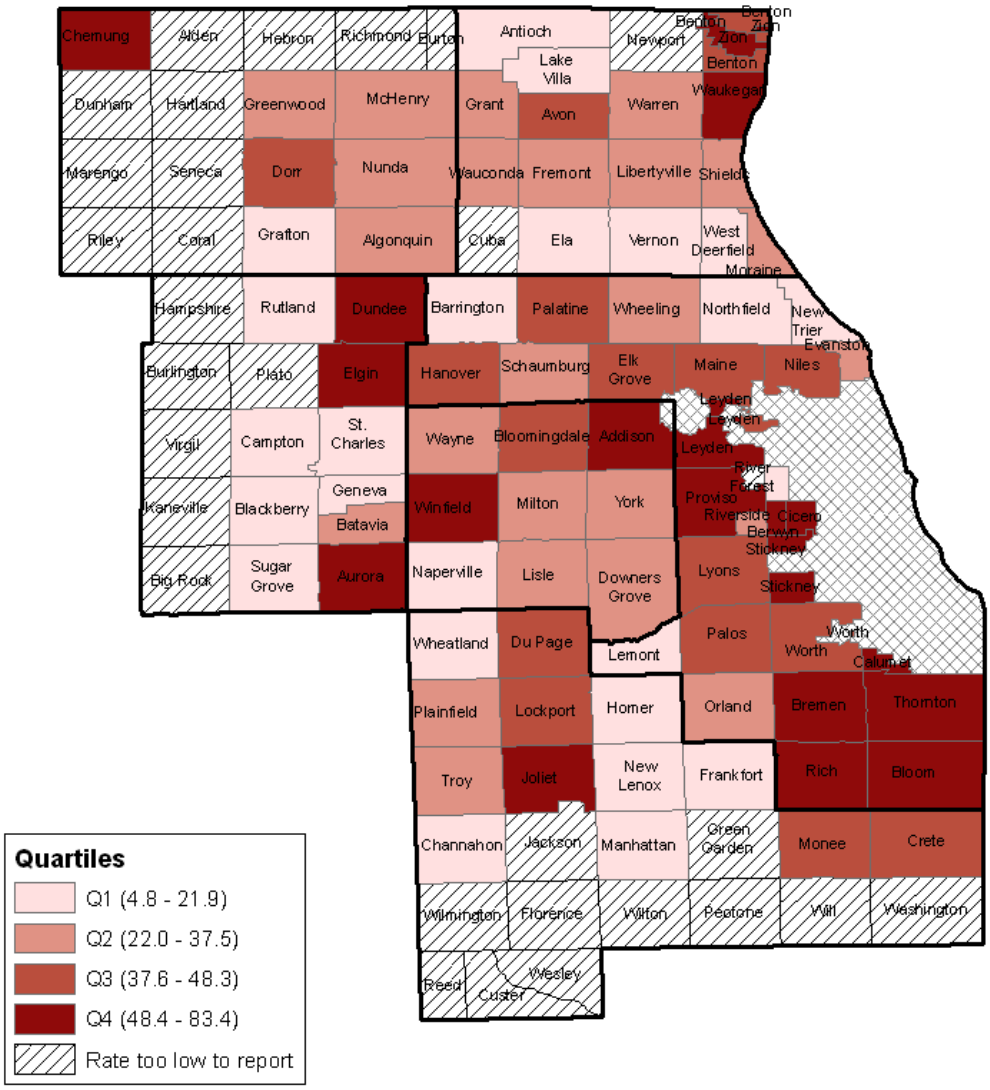


Cook and Collar Counties: Townships

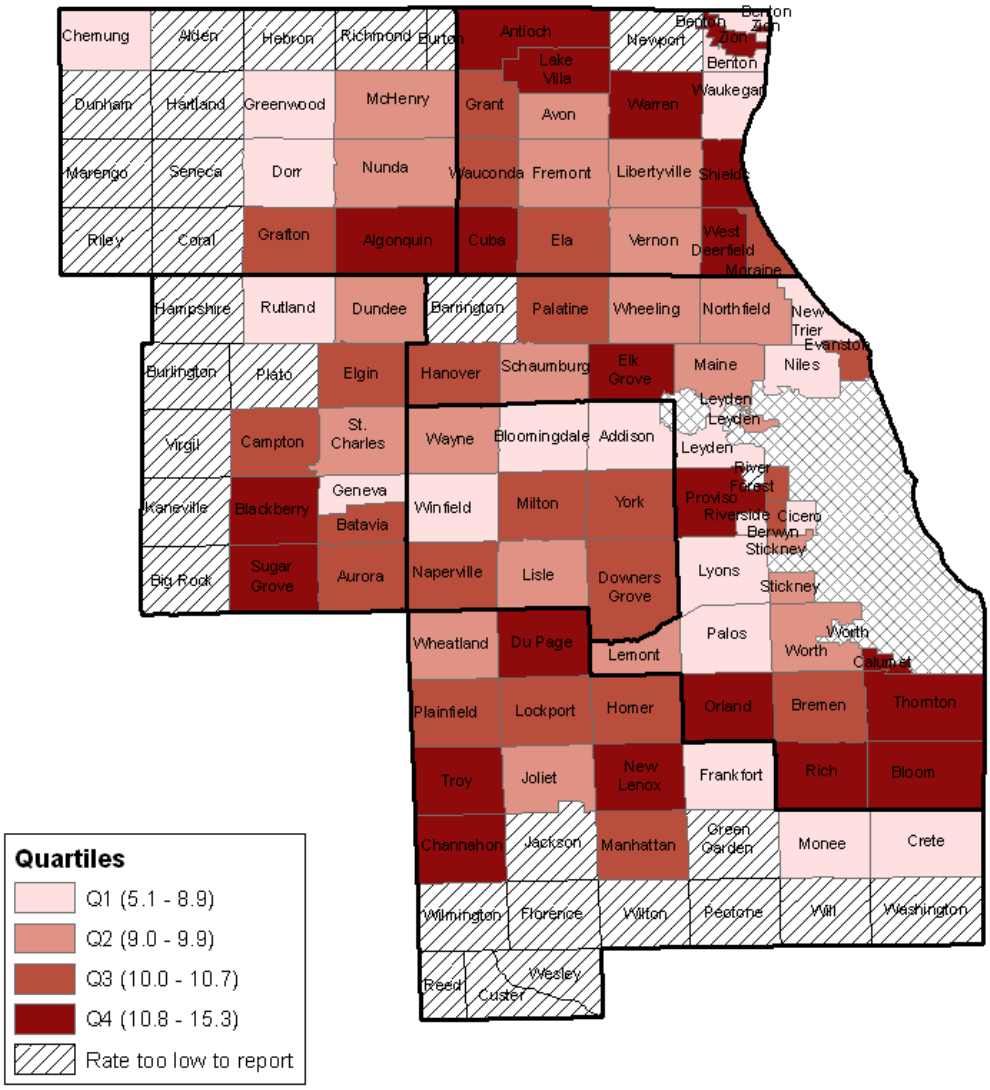
Cook and Collar Counties: Townships
Birth Rate



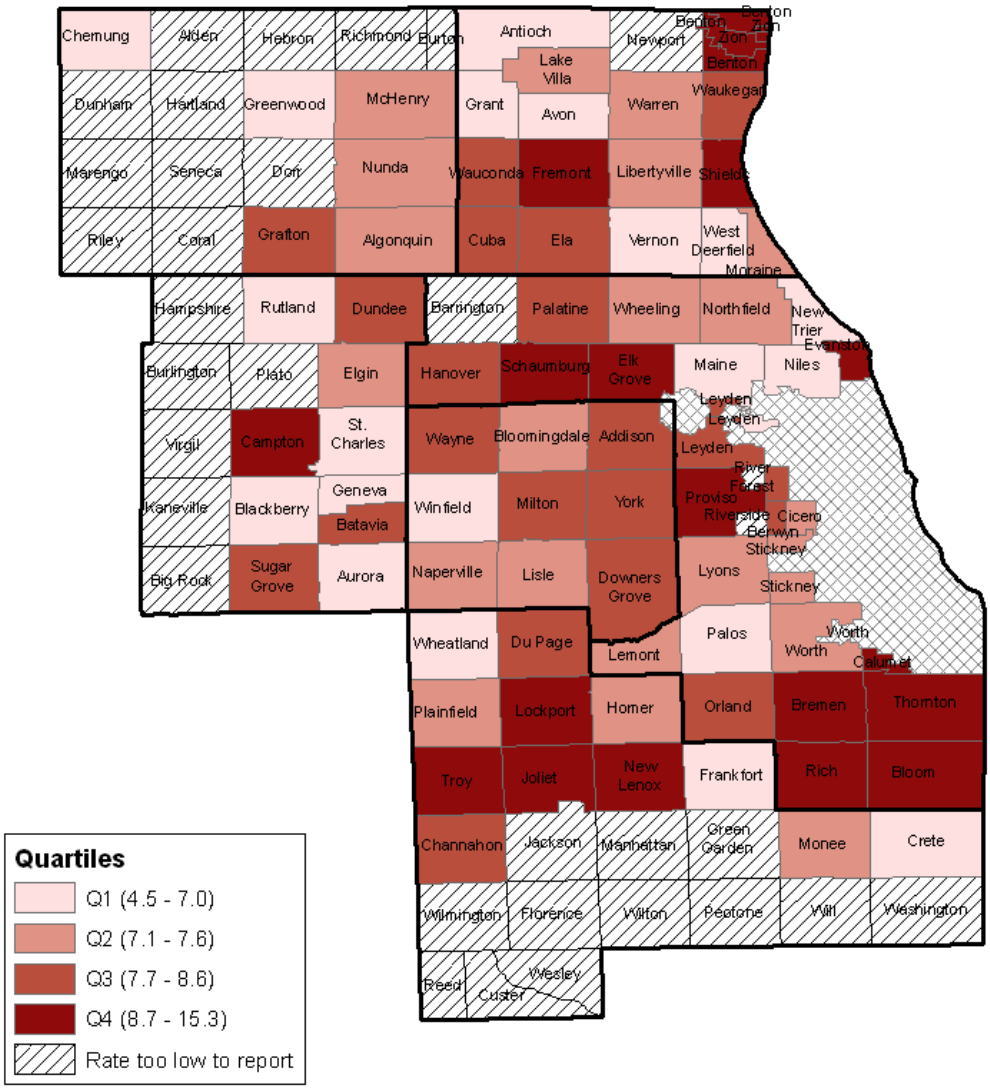
Cook and Collar Counties: Townships
Percent of Births: Medicaid Paid



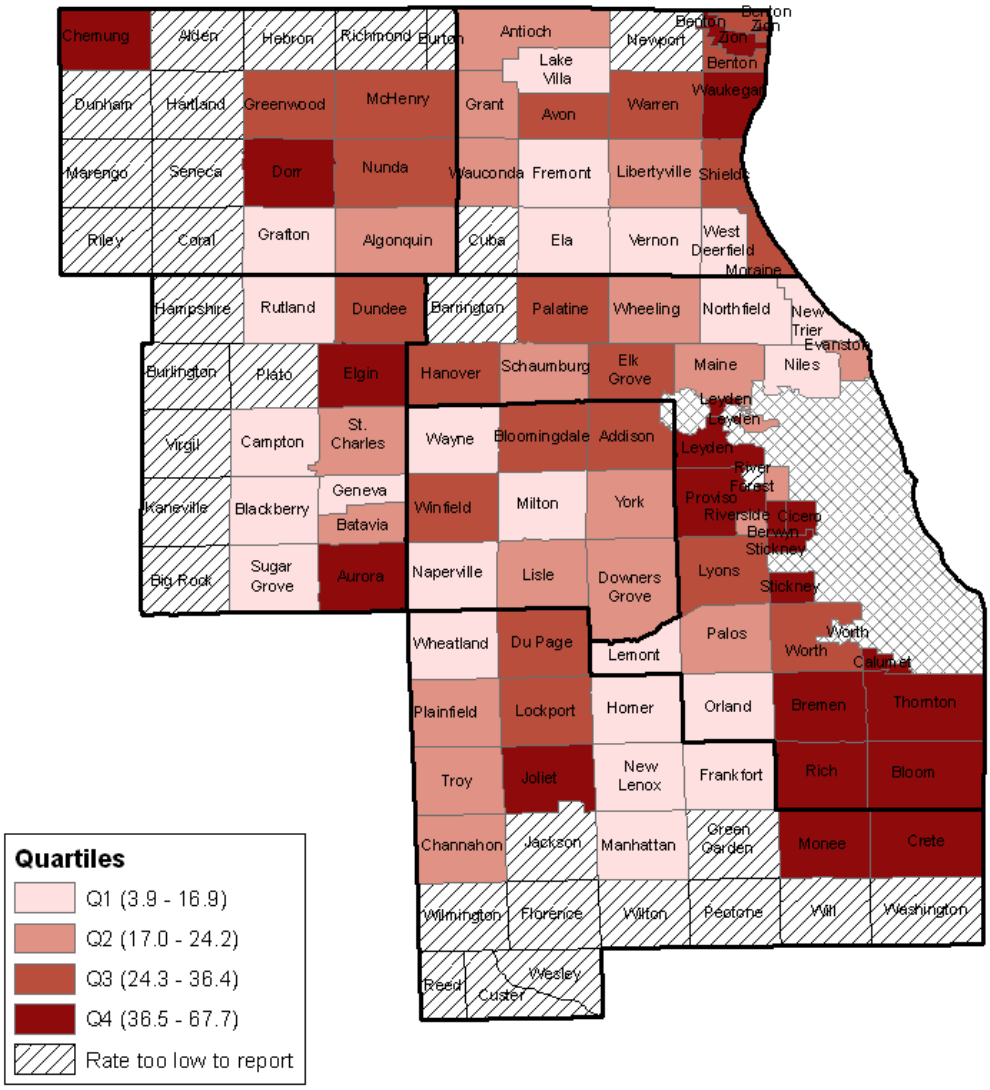
Cook and Collar Counties: Townships
Percent of Births: Premature



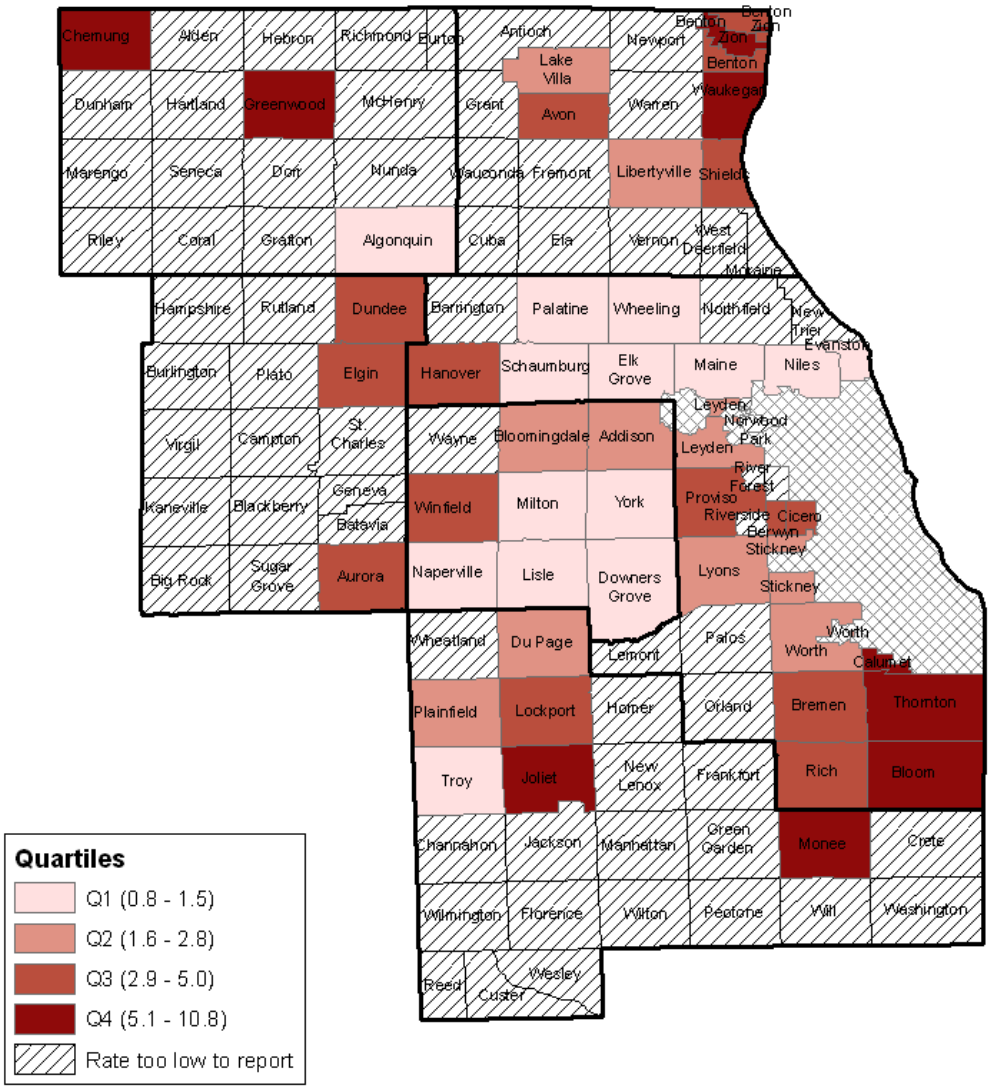
Cook and Collar Counties: Townships
Percent of Births: Low Birth Weight



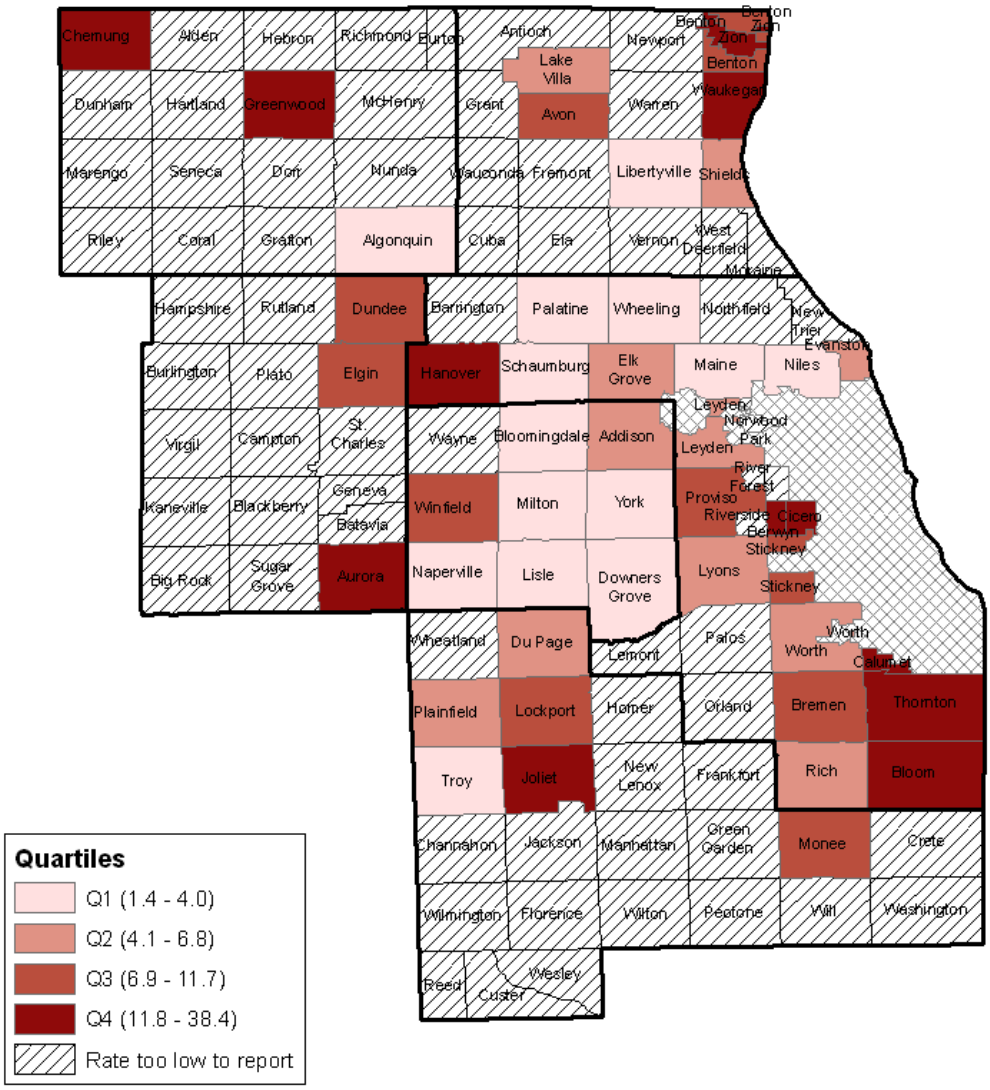
Cook and Collar Counties: Townships
Percent of Births: Single Mothers



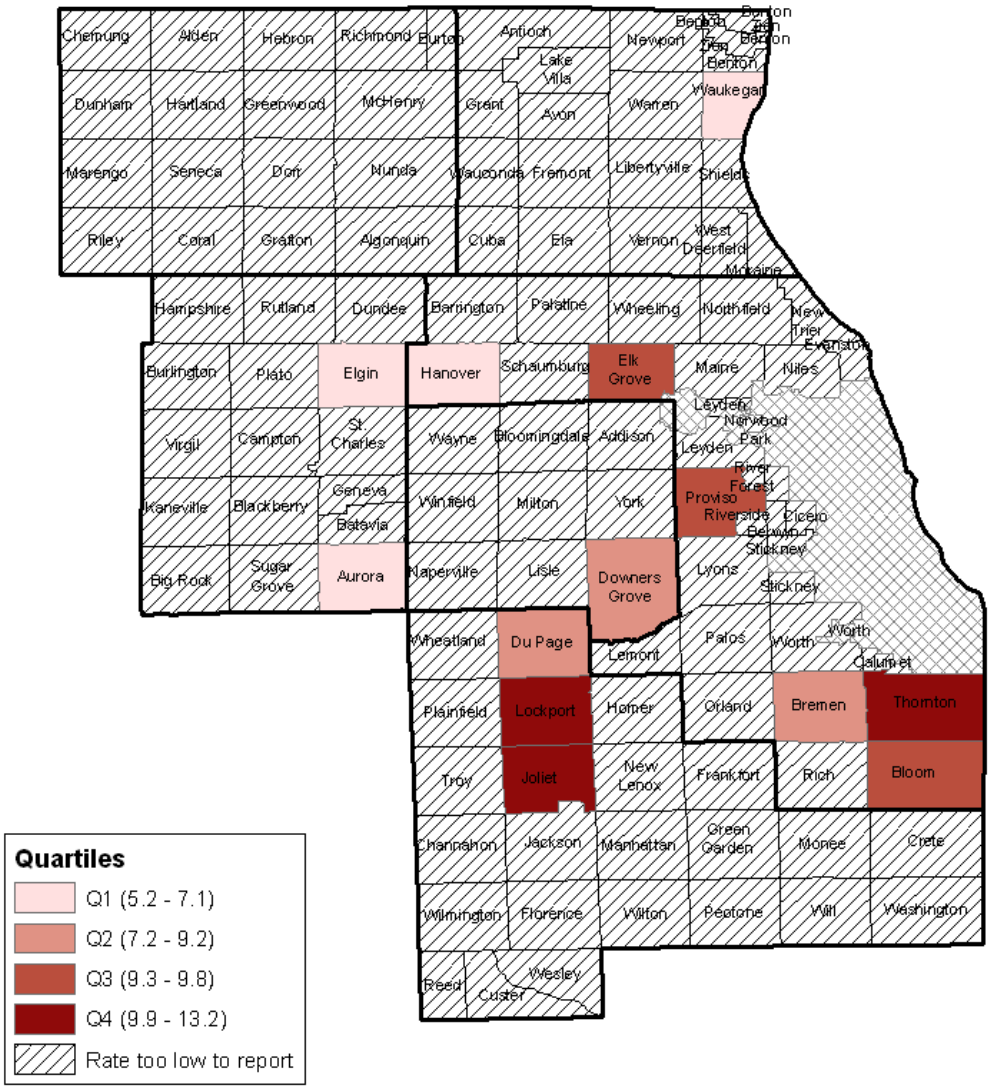
Cook and Collar Counties: Townships
Percent of Births: Teenage Mothers (<17)



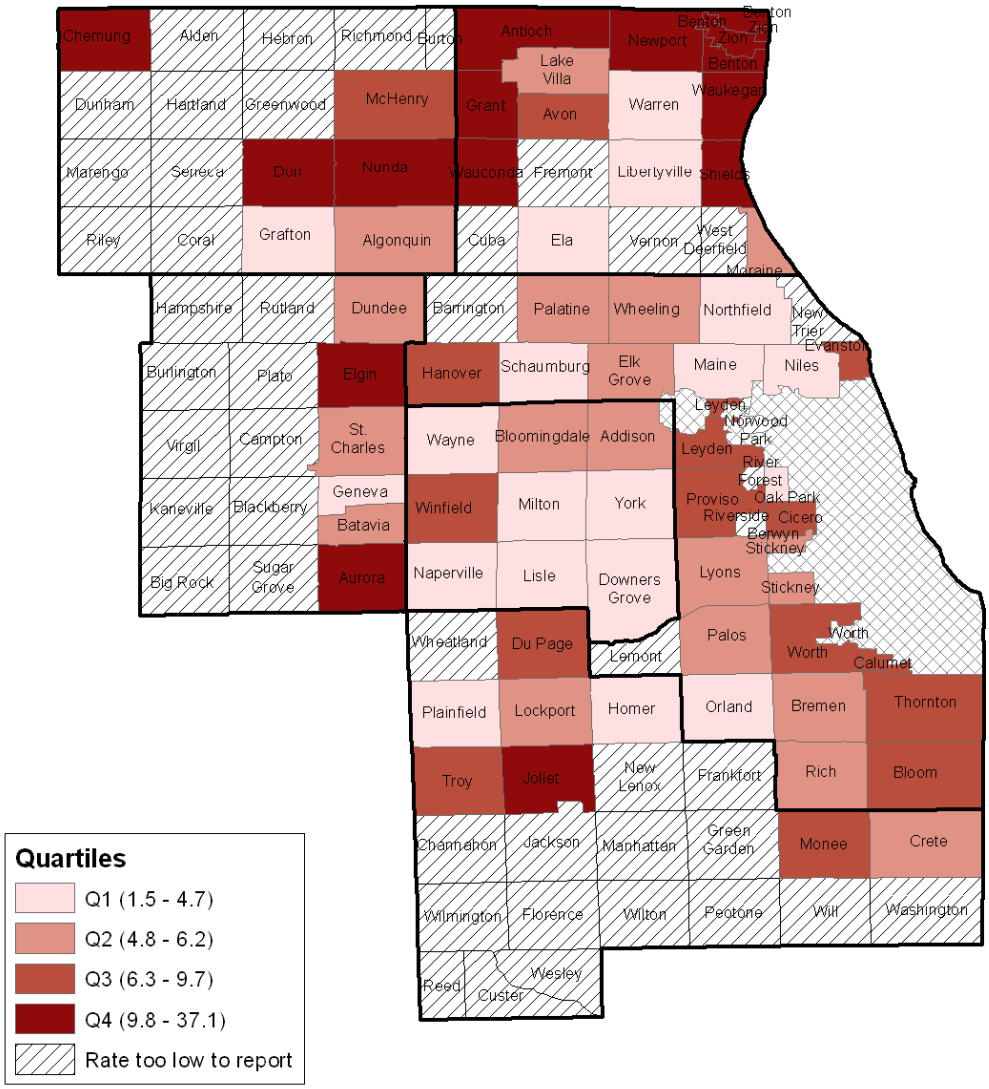
Cook and Collar Counties: Townships
Teen Birth Rate



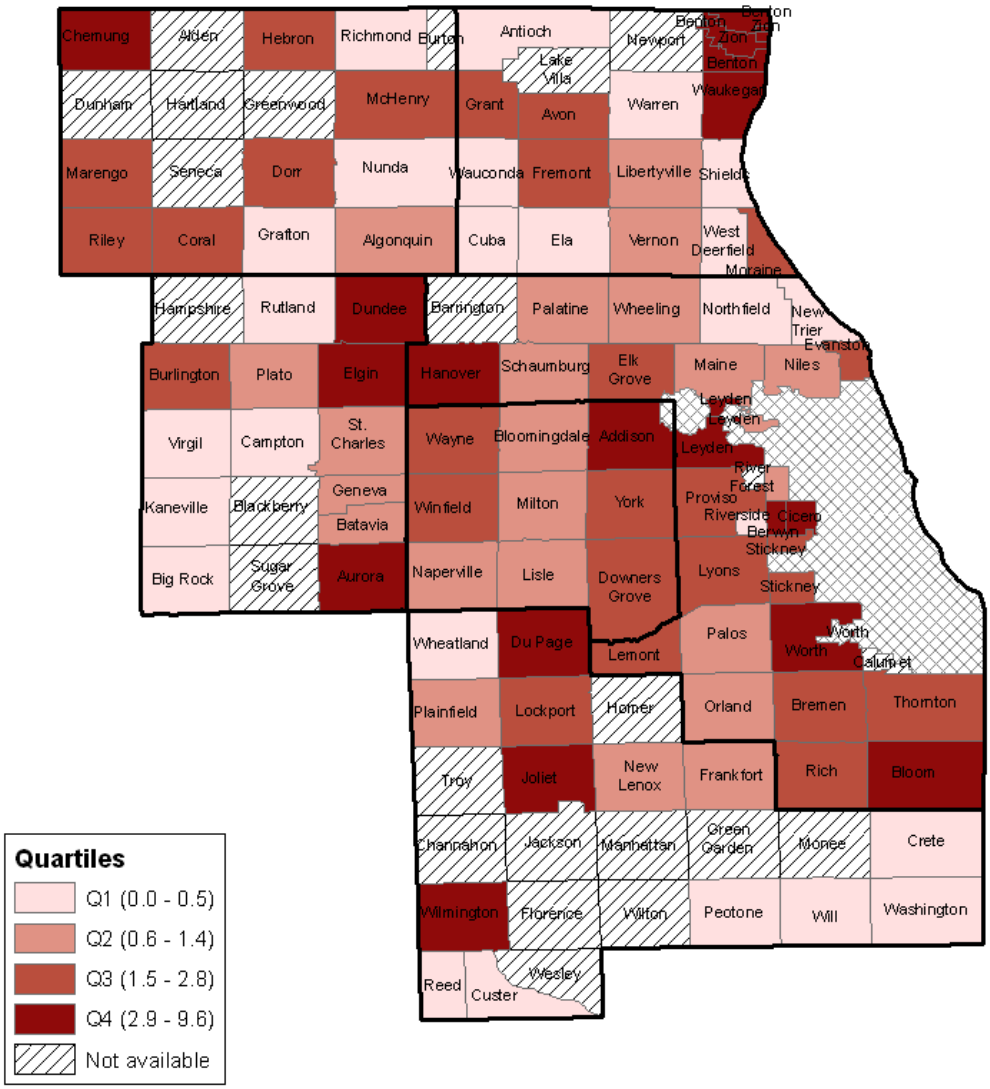
Cook and Collar Counties: Townships
Infant Mortality Rate



Cook and Collar Counties: Townships
Child Abuse and Neglect Rate

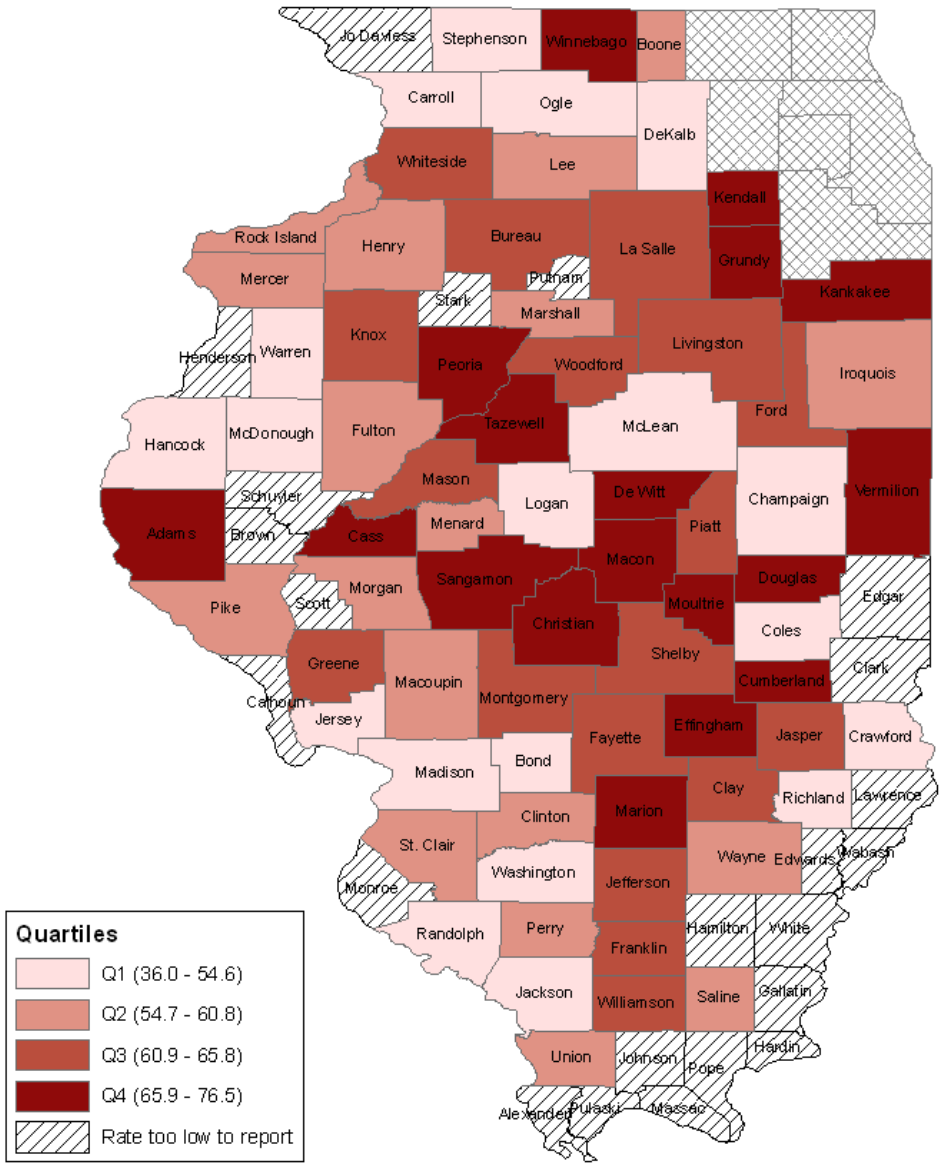


Cook and Collar Counties: Townships
High School Dropout Rate

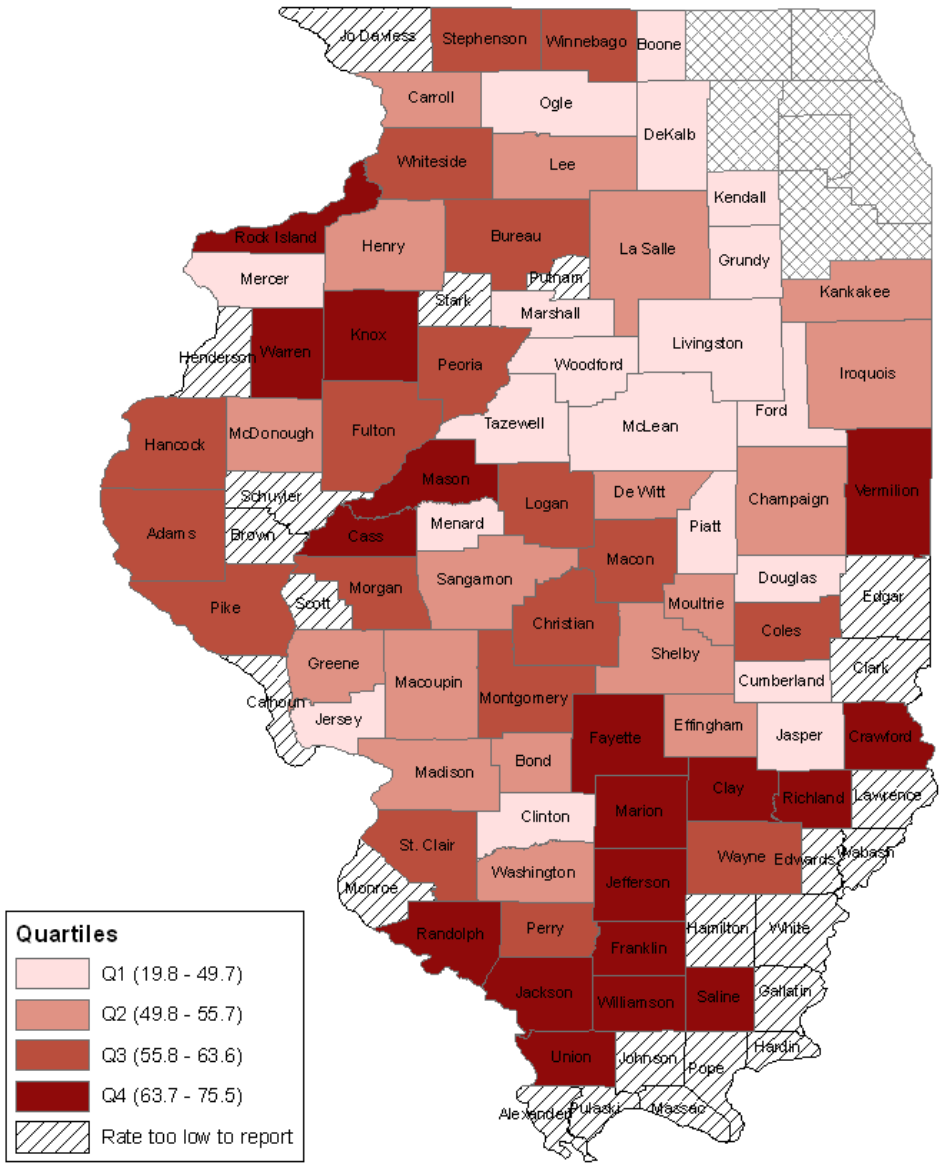


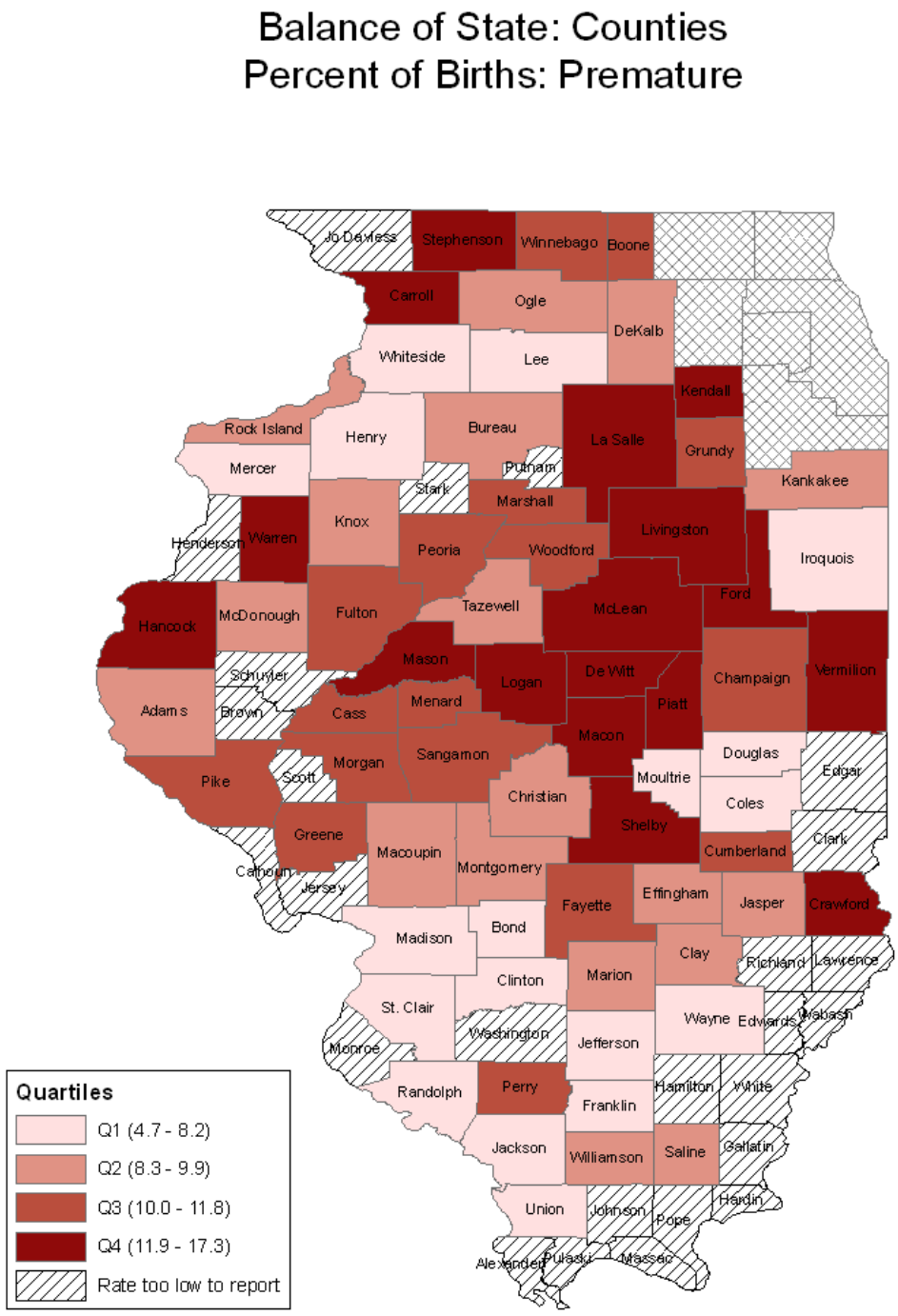
Balance of State: Counties

Balance of State: Counties
Birth Rate

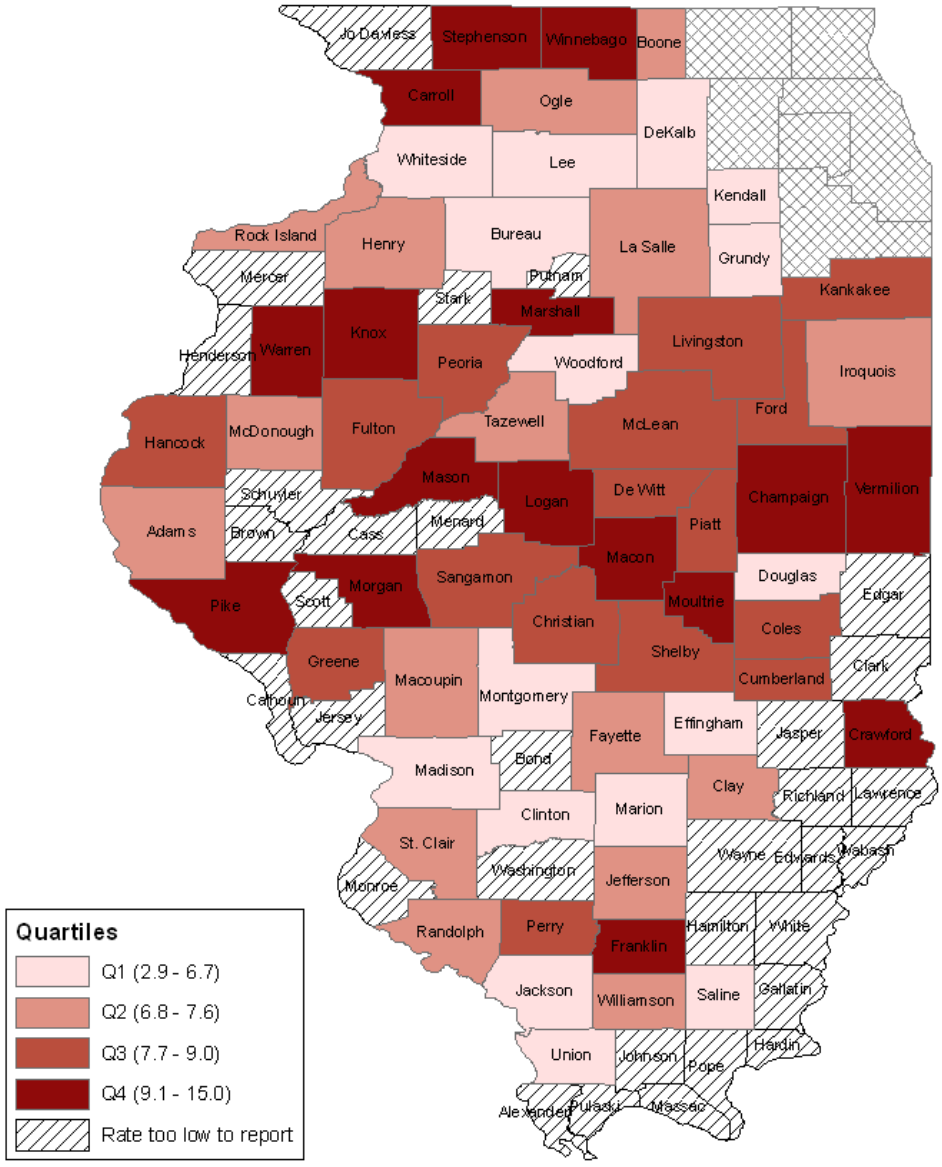


Balance of State: Counties
Percent of Births: Medicaid Paid

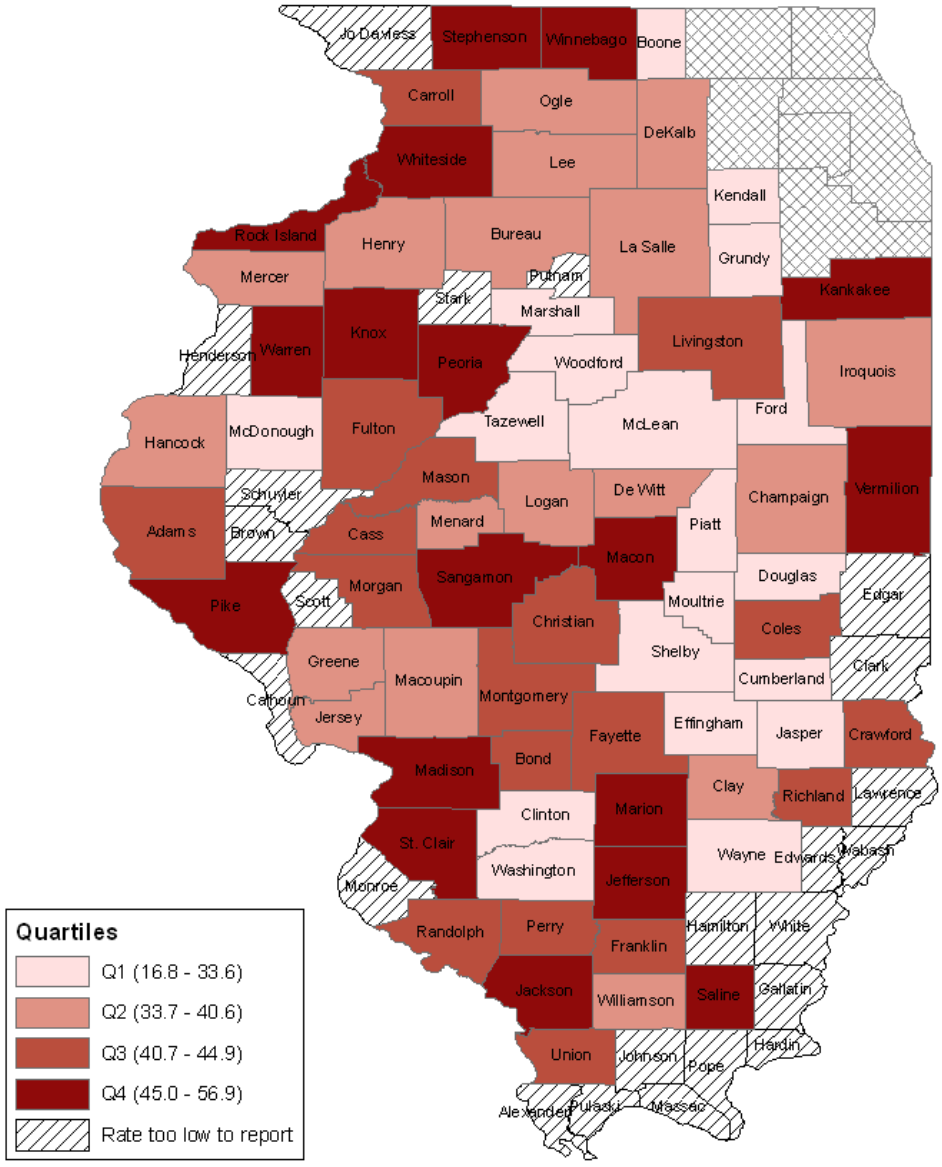



Balance of State: Counties
Percent of Births: Premature
Jo Daviess
Stephenson
Winnebago
Boone
Carroll
Ogle
DeKalb
Whiteside
Lee
Kendall
Rock Island
Henry
Bureau
La Salle
Grundy
Mercer
Putnam
Kankakee
Stark
Marshall
Knox
Livingston
Henderson
Warren
Peoria
Woodford
Iroquois
Hancock
McDonough
Fulton
Tazewell
McLean
Ford
Mason
Logan
De Witt
Champaign
Vermilion
Schuyler
Adams
Brown
Cass
Menard
Piatt
Macon
Douglas
Edgar
Morgan
Sangamon
Moultrie
Pike
Scott
Christian
Coles
Greene
Shelby
Clark
Cumberland
Macoupin
Montgomery
Calhoun
Jersey
Fayette
Effingham
Jasper
Crawford
Madison
Bond
Clay
Richland
Lawrence
Clinton
Marion
St. Clair
Wayne
Edwards
Wabash
Washington
Jefferson
Monroe
Randolph
Perry
Hamilton
White
Franklin
Jackson
Williamson
Saline
Gallatin
Union
Johnson
Pope
Hardin
Alexander
Pulaski
Massac
Quartiles
Q1 (4.7 - 8.2)
Q2 (8.3 - 9.9)
Q3 (10.0 - 11.8)
Q4 (11.9 - 17.3)
Rate too low to report

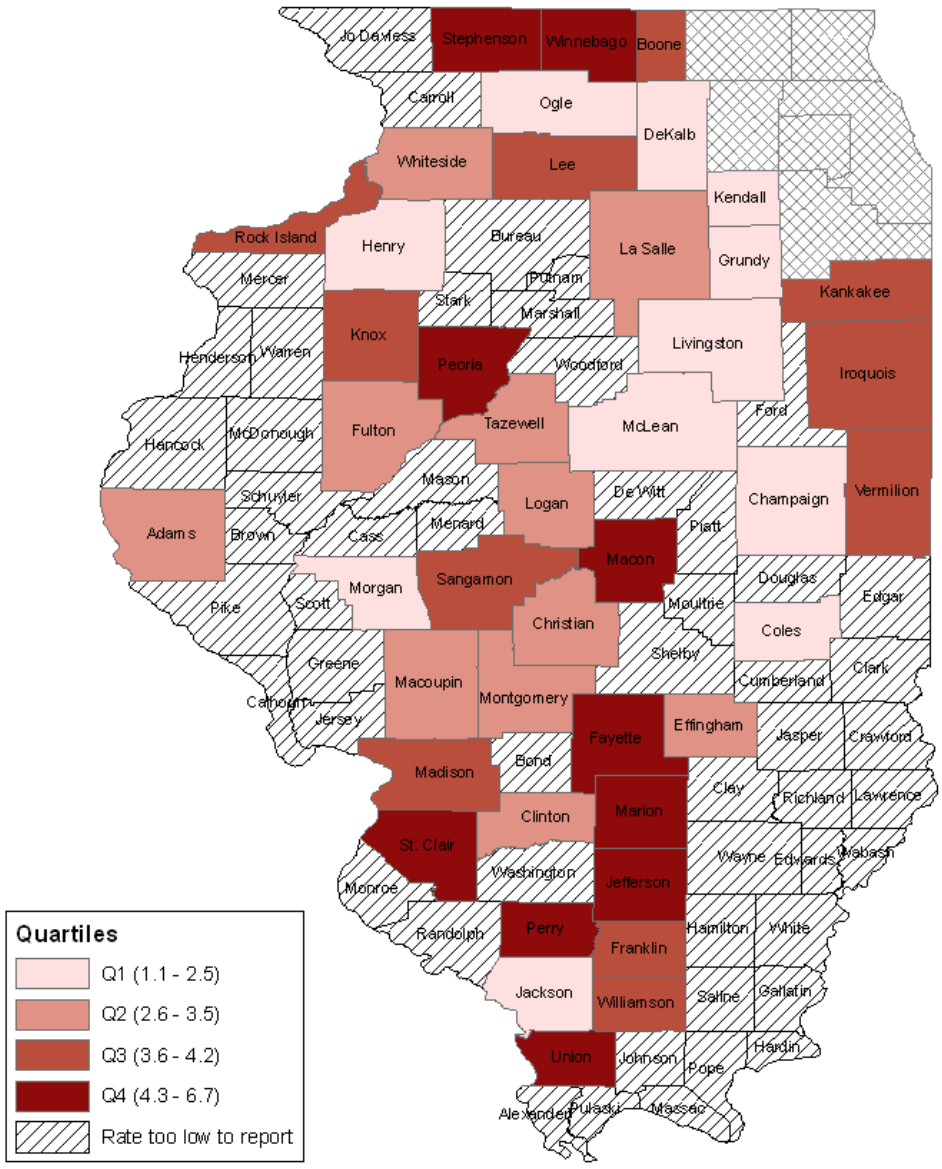
Balance of State: Counties
Percent of Births: Low Birth Weight



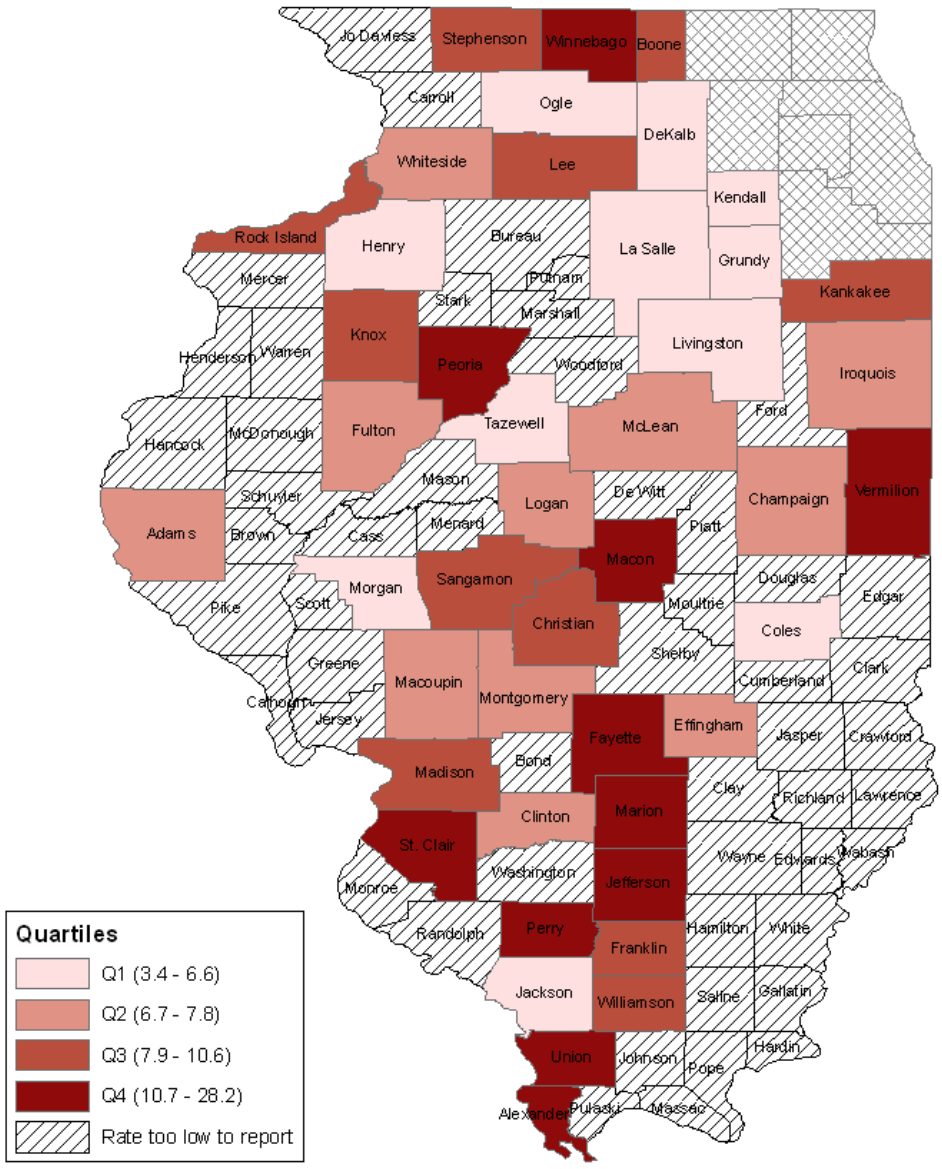
Balance of State: Counties
Percent of Births: Single Mothers



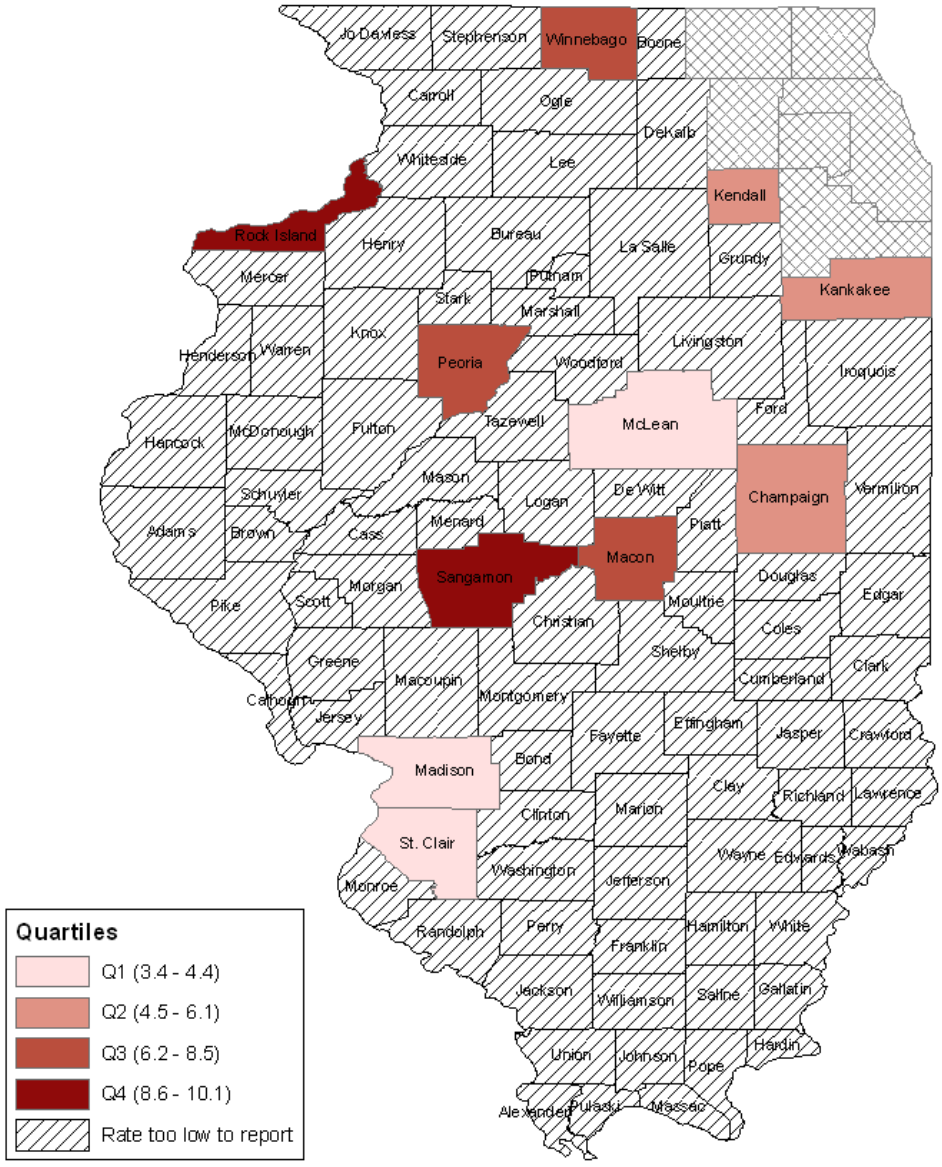
Balance of State: Counties
Percent of Births: Teenage Mothers (<17)



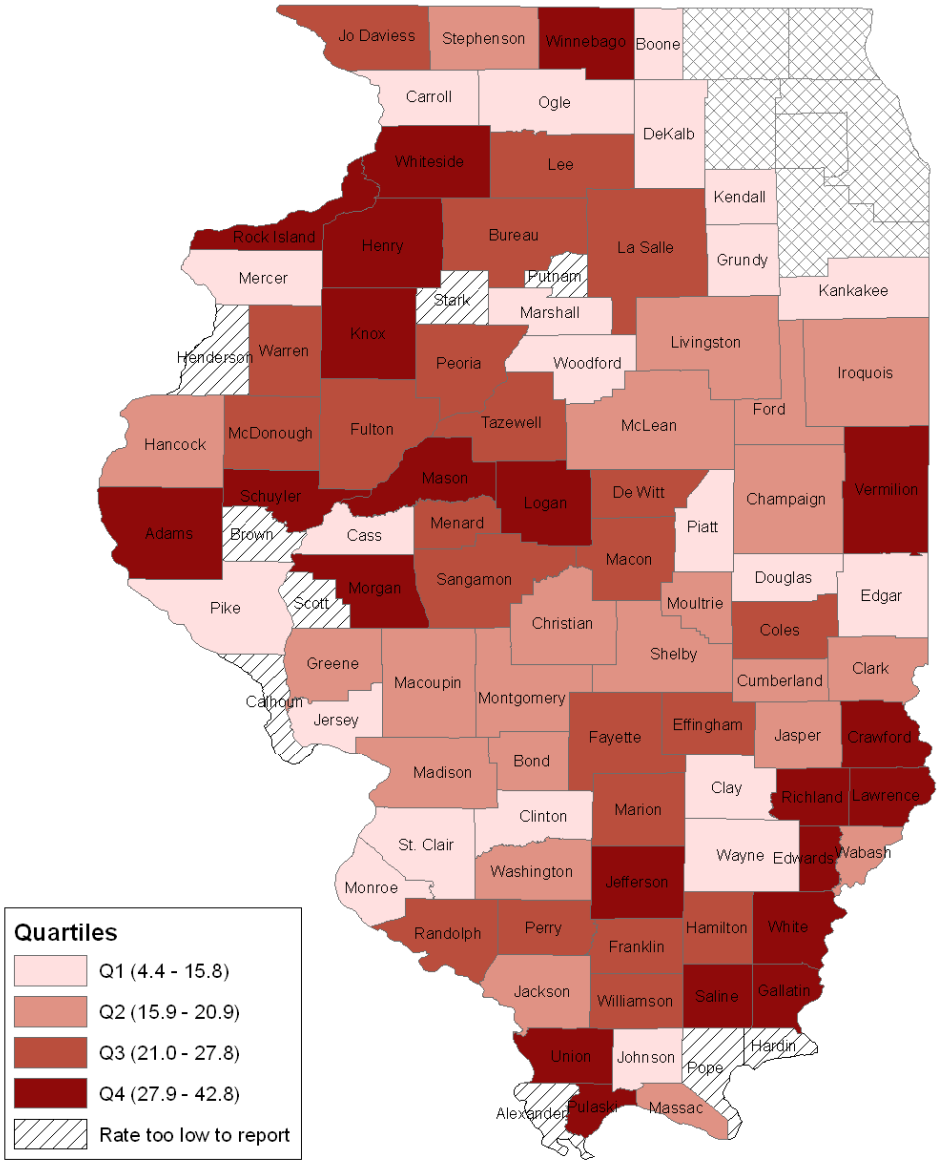
Balance of State: Counties
Teen Birth Rate

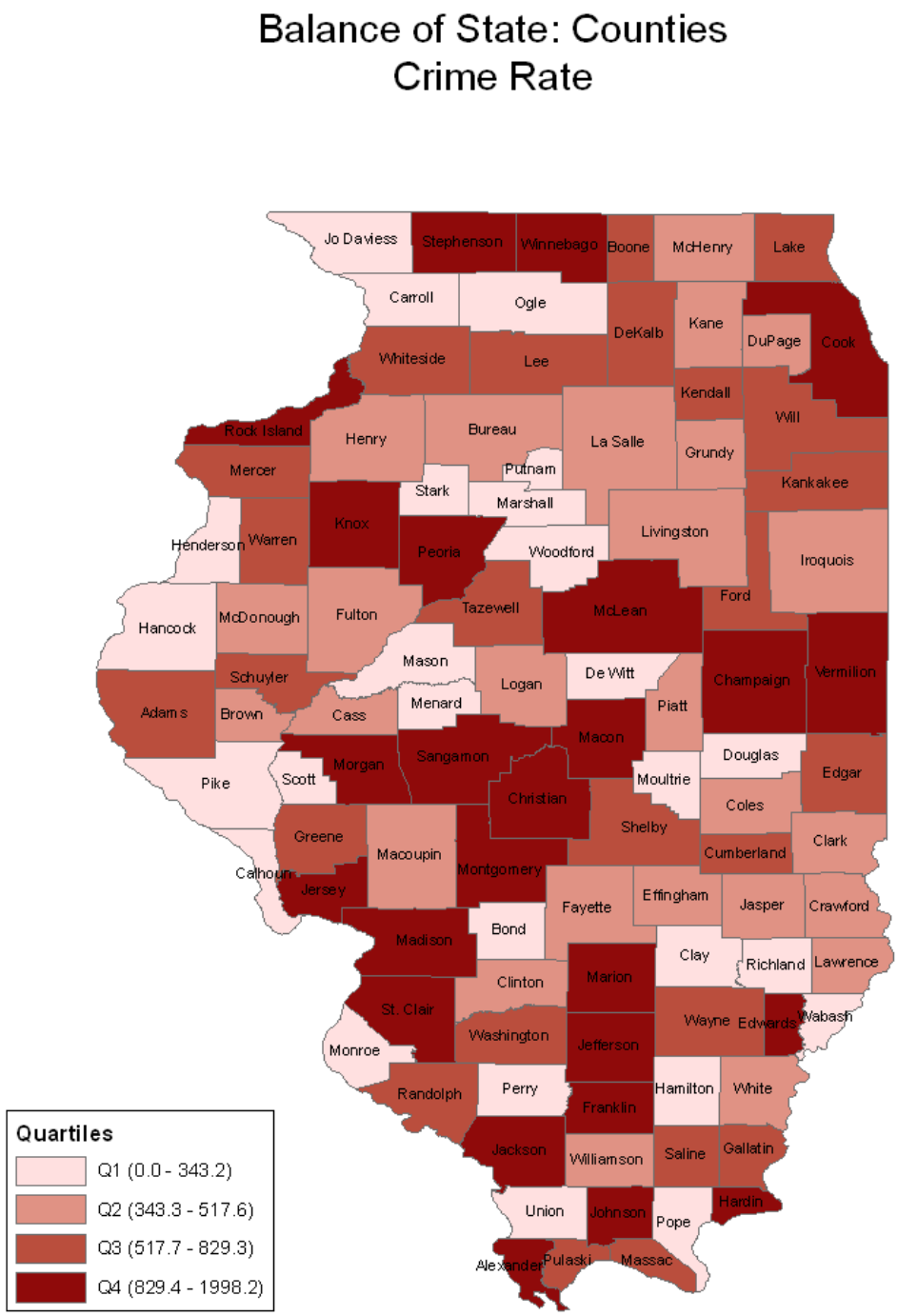


Balance of State: Counties
Infant Mortality Rate

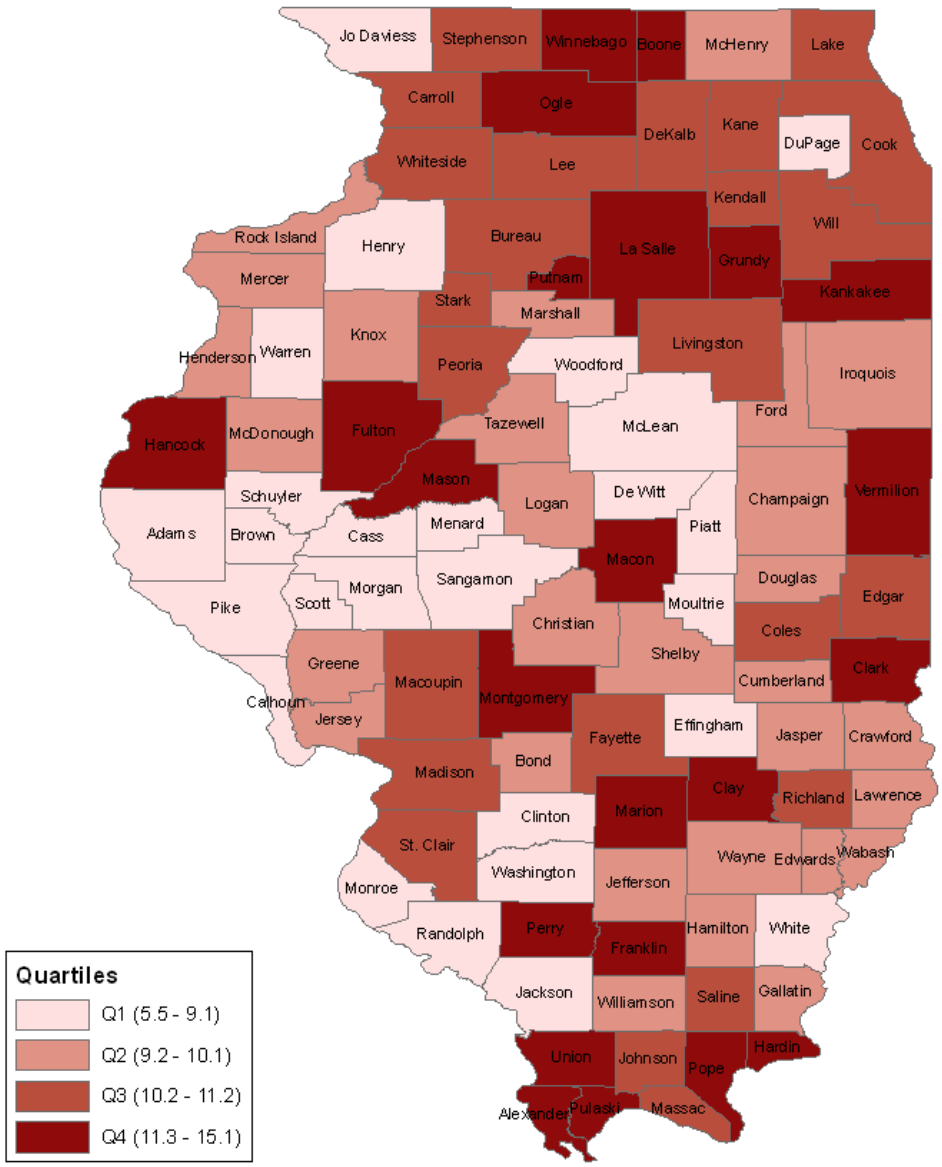


Balance of State: Counties
Child Abuse and Neglect Rate

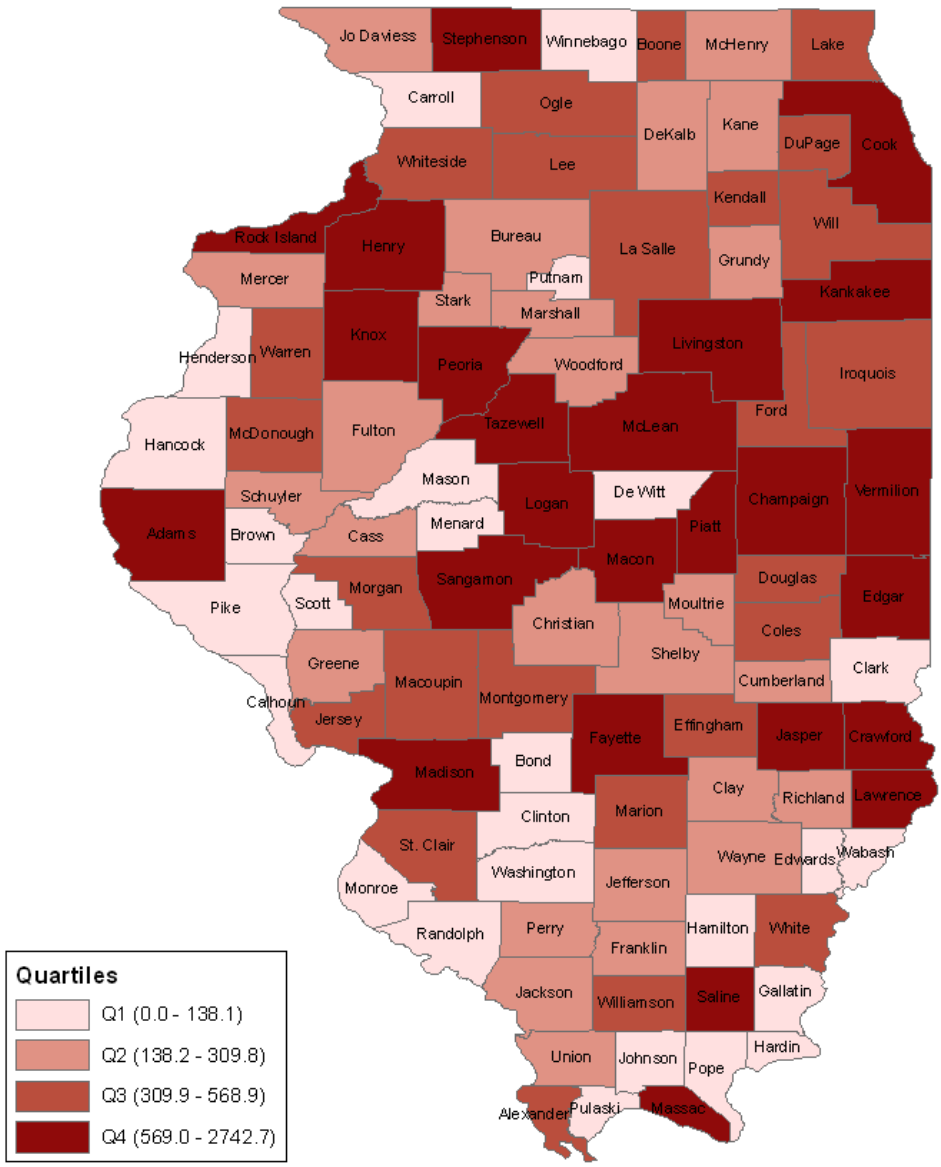



Balance of State: Counties
Crime Rate
Jo Daviess
Stephenson
Winnebago
Boone
McHenry
Lake
Carroll
Ogle
DeKalb
Kane
DuPage
Cook
Whiteside
Lee
Kendall
Will
Rock Island
Henry
Bureau
La Salle
Grundy
Mercer
Putnam
Kankakee
Stark
Marshall
Knox
Livingston
Henderson
Warren
Peoria
Woodford
Iroquois
Hancock
McDonough
Fulton
Tazewell
McLean
Ford
Mason
Logan
De Witt
Champaign
Vermilion
Schuyler
Adams
Brown
Cass
Menard
Piatt
Macon
Douglas
Edgar
Morgan
Sangamon
Moultrie
Pike
Scott
Christian
Coles
Shelby
Greene
Macoupin
Cumberland
Clark
Calhoun
Montgomery
Jersey
Fayette
Effingham
Jasper
Crawford
Madison
Bond
Clay
Richland
Lawrence
Clinton
Marion
St. Clair
Wayne
Edwards
Wabash
Washington
Jefferson
Monroe
Randolph
Perry
Hamilton
White
Franklin
Jackson
Williamson
Saline
Gallatin
Union
Johnson
Pope
Hardin
Alexander
Pulaski
Massac
Quartiles
Q1 (0.0 - 343.2)
Q2 (343.3 - 517.6)
Q3 (517.7 - 829.3)
Q4 (829.4 - 1998.2)

Statewide County Distribution
Unemployment Rate



Statewide County Distribution
Domestic Violence Crime Rate



Balance of State: Counties
High School Dropout Rate